

## MARYLAND STATE DEPARTMENT OF HEALTH

00196

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 35

212

1. PLACE OF DEATH: COUNTY <u>BALTIMORE</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD.</u> COUNTY <u>HARFORD</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>COCKEYSVILLE</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>WHITE HALL RD.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>YORK RD.</u>		STREET ADDRESS (If rural, give location) <u>12x-2</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>JOHN</u> (Middle) <u>ROD</u> (Last) <u>ADAMS</u>	4. DATE OF DEATH	(Month) <u>JAN</u> (Day) <u>20</u> (Year) <u>1956</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>9-2-00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PARADE OWNER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>-</u>	9. AGE last birthday <u>55</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN HENRY ADAMS</u>		14. MOTHER'S MAIDEN NAME <u>HENRIETTA MON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>214-34-4726</u>	
17. INFORMANT AND ADDRESS <u>WIFE - Nola R. Adams</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>420.1 MYOCARDIAL INFARCTION</u>			<u>1 MIN.</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			<u>3 YRS.</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, or office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>William C. Pillsbury</u>		DATE SIGNED <u>1/20/56</u>	
(Degree or title) <u>M.D.</u>		ADDRESS <u>Tamona</u>	
23. REMOVAL (Specify)	DATE THEREOF <u>Jan 23-56</u>	NAME OF CEMETERY OR CREMATORY <u>Bethel</u>	LOCATION (City, town, or county) (State) <u>Madonna Harford MD</u>
24. FUNERAL DIRECTOR	DATE REC'D BY LOCAL REG. <u>1-22-56</u>	REGISTRAR'S SIGNATURE <u>Mrs Howard S. Markline</u>	ADDRESS <u>1100 W. 2nd St. Beltsville Md</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 27 1956

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00197

213

## CERTIFICATE OF DEATH

Reg. Dist. No. 3/

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hebbville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hebbville</u>	
TOWN <u>Hebbville</u>		TOWN <u>Hebbville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rolling Road &amp; Clays Ln.</u>		STREET ADDRESS (If rural, give location) <u>Rolling Road &amp; Clays Ln.</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Annie E. Ahring</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 9, 1956</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>S</u>	8. DATE OF BIRTH <u>3/20/ 1882</u>
9. AGE last birthday <u>73</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		12. CITIZEN OF WHAT COUNTRY <u>USA</u>	
13. FATHER'S NAME <u>William E. Ahring</u>		14. MOTHER'S MAIDEN NAME <u>Mollie R. ?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give year or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>	
17. INFORMANT <u>James Klaus PO 7664 Balto, 7, Md.</u>			

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	INTERVAL BETWEEN ONSET AND DEATH
420.1 Immediate cause (a) <u>Coronary Thrombosis</u>	<u>3 wks.</u>
Antecedent cause(s) (b) <u>Hypertensive Cardio-Vascular Renal Disease</u>	<u>10 years</u>
(c)	

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.	
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT (Specify) <u>SUICIDE</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>
(CITY OR TOWN)	(COUNTY)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>m.</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>
HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from <u>Aug 10, 1953</u> , to <u>January 9, 1956</u> , that I last saw the deceased alive on <u>1/9/56</u> , 1956, and that death occurred at <u>2:01 P.M.</u> , from the causes and on the date stated above.	
SIGNATURE <u>Edwin L. Simpson, M.D.</u>	ADDRESS <u>8204 Lehigh Rd, Balto 7, Md</u>
DATE SIGNED <u>1/11/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan. 13, 56</u>
NAME OF CEMETERY OR CREMATORY <u>Western</u>	LOCATION (City, town, or county) <u>Baltimore Md.</u>
24. FUNERAL DIRECTOR <u>John T. Stansbury</u>	ADDRESS <u>6411 Windsor Mill Balto. 7 Md.</u>
DATE REC'D BY LOCAL REG. <u>1-11-56</u>	REGISTRAR'S SIGNATURE <u>Aug. L. Borsall</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 24 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A13C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

214

## CERTIFICATE OF DEATH

00198

Reg. Dist. No. 30

Item 9, Film 6192 2-6-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Ma.</u>		COUNTY <u>Balto.</u>	
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place)		CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>20 128 Rosewood Ave.</u>				STREET ADDRESS (If rural give location) <u>128 Rosewood Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anna</u> (Middle) <u>McGraw</u> (Last) <u>Anderson</u>				(Month) <u>Jan.</u> (Day) <u>1</u> (Year) <u>19 56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>March 16, 1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John W. McGraw</u>				14. MOTHER'S MAIDEN NAME <u>Jane E. Dillo</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>--</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT & ADDRESS <u>Miss Agnes McGraw 128 Rosewood Av</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>420d Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) <u>Hypertensive Cardio Vascular Disease</u>							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/5/56</u> , 19 <u>56</u> , to <u>1/1/56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/1/56</u> , and that death occurred at <u>9:45 PM</u> from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>1/3/56</u>		ADDRESS (Street, city, town, state) <u>M.D. 17107 Edmondson Ave. (28) Md</u>			
23. BURIAL, CREMATION REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-4-56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cem.</u>		LOCATION (City, town, or county) (State) <u>Harper Ferry, W. Va.</u>	
24. REC'D BY REGISTRAR DATE <u>JAN 10 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. [Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Fowler Funeral Home, Catonsville, Md.</u>			

# CERTIFICATE OF DEATH

215

Case No. 100

DEATH RECORDS DIVISION - BOSTON

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BUREAU V. S.

JAN 11 1956

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-45 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

215

## CERTIFICATE OF DEATH

00199

Reg. Dist. No. 38

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
53 TOWN <u>TOWSON</u>		18 <u>mo</u>		TOWN <u>Towson</u>		55	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
90 <u>Stella Maris Hospice</u>				<u>Pot Spring Rd-</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last)				(Month) (Day) (Year)			
<u>Elizabeth Magdalene Angevine</u>				<u>1-1-1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>W</u>	<u>Feb 27 1883</u>	<u>72</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>??</u>		<u>Penna.</u>		<u>U.S.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>John Wise</u>				<u>Clara Doehler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>??</u>		<u>HOSPICE RECORDS</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
442X IMMEDIATE CAUSE (A)				<u>Acute Pulmonary Edema</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>Hypertensive Cardia-</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				<u>Renal Vascular Dec-</u>			
				<u>10 yrs</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>March 19 55</u> , to <u>Jan 1 19 56</u> , that I last saw the deceased alive on <u>Dec 31 19 55</u> , and that death occurred at <u>8:27 A.M.</u> from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>Charles F. O'Donnell M.D.</u>				<u>2501 York Rd - Towson</u>		<u>Jan 1 19 56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/3/56</u>		<u>Mt. Olivet Cemetery</u>		<u>Frederick, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
JAN 4 1956		<u>Mabel Gray</u>		<u>John A. Moran</u>		<u>3000 E. Baltimore St.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00200  
215  
CERTIFICATE OF DEATH

Reg. Dist. No. 3

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Balto.		MARYLAND		STATE Md.		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Ruxton		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Balto/ 3601-4			
HOSPITAL OR INSTITUTION OR STREET ADDRESS Sorenson Nursing Home				STREET ADDRESS (If rural give location) 3624 Greenmount Ave.			
3. NAME OF DECEASED: (First) CORA		(Middle) M.		(Last) ARMELING		4. DATE (Month) (Day) (Year) OF DEATH: Jan. 27, 19 56	
5. SEX: Female	6. COLOR OR RACE: White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed	8. DATE OF BIRTH: Jan. 30, 1884	9. AGE last birthday: 71 yrs.	IF UNDER 1 YEAR Months II	IF UNDER 24 HRS. Days 27	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): never worked			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: William G. H. King				14. MOTHER'S MAIDEN NAME: Julia Conrad			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no		16. SOCIAL SECURITY No. none		17. INFORMANT & ADDRESS: Ave. Mrs. Rita M. Schilling - 3624 Greenmount			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) Carcinomatous metastasis						1 year	
ANTECEDENT CAUSE (S): (B) Myocarditis chronic						5 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) Hypertrophy myocardium C failure						2 years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. Carcinoma intestinal.						unknown	
19A. DATE OF OPERATION: Dec. 1955		19B. MAJOR FINDINGS OF OPERATION: Refer to Union Memorial Hosp. (Colostomy)					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) none		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? no injury			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY no injury M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? no injury			
22. I hereby certify that I attended the deceased from Jan 16, 1956, to Jan 27, 19 56 that I last saw the deceased alive on Jan 20, 19 56, and that death occurred at 11:30 M, from the causes and on the date stated above.							
SIGNATURE James Graham Martin				ADDRESS M. D. 516 Cathedral Street		DATE SIGNED Jan 28-56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 1/30/56		NAME OF CEMETERY OR CREMATORY Druid Ridge Cem.		LOCATION (City, town, or county) (State) Pikesville, Md.	
DATE REC'D BY LOCAL REGISTRAR January 28/1956		REGISTRAR'S SIGNATURE Rar.		FUNERAL DIRECTOR M. J. Dickner		ADDRESS 4400 - Balto 17 Md	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





217

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place) <u>1yr24days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Cockeysville</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14</u> <u>Spring Grove State Hospital</u>				STREET ADDRESS (If rural give location) <u>Cockeysville Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Gertrude</u> <u>Virginia</u> <u>Aspden</u>				4. DATE (Month) (Day) (Year) OF DEATH <u>January 4,</u> <u>19 56</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>10-7-1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Arment</u>				14. MOTHER'S MAIDEN NAME: <u>Van Luvanie</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.1</u> <u>Coronary thrombosis</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Arteriosclerotic cardiovascular disease</u>							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12-11-1954</u> , to <u>1-4-1956</u> , that I last saw the deceased alive on <u>1-4-1956</u> , and that death occurred at <u>2:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachler</u>		ADDRESS <u>Spring Grove State Hospital</u>		DATE SIGNED <u>1-4-56</u>		M. D. <u>Catonsville 28, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 7 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cem.</u>		LOCATION (City, town, or county) (State) <u>Towson, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-6-56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		24. FUNERAL DIRECTOR <u>John Brown</u>		ADDRESS <u>Anne Towson, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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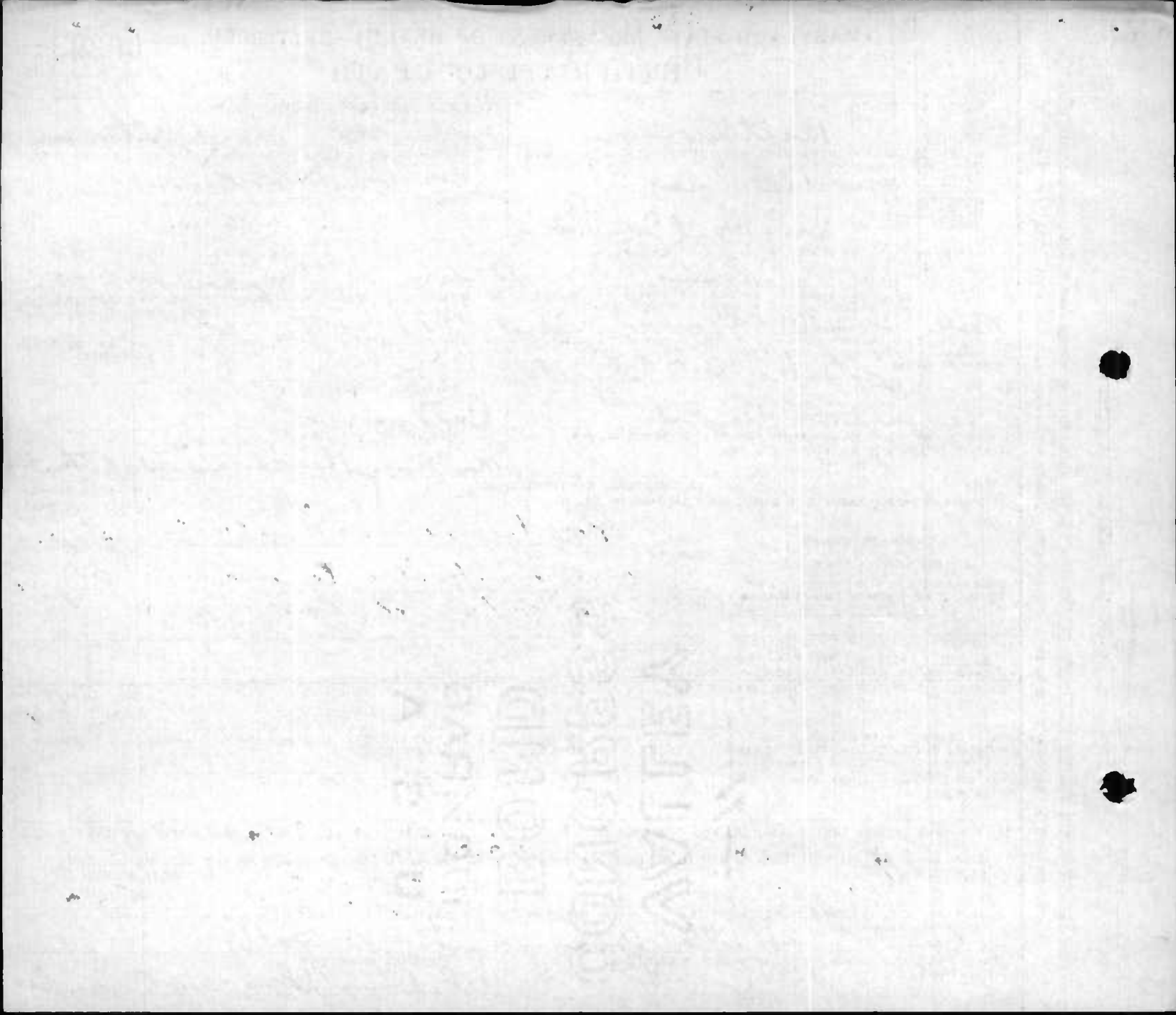
JAN 9 1956

BUREAU V. S.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

213 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18				00202
Item 2 ByPhone -Nursing Home 1-31-56 ams				Reg. Dist. No. 4
CERTIFICATE OF DEATH				
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	Baltimore	STATE	Md	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	54 Middle River	CITY (If outside corporate limits, write RURAL OR and give nearest town)	Baltimore	3001.4
HOSPITAL OR INSTITUTION OR STREET ADDRESS	90 Iny Hall Con Home	STREET ADDRESS	261 S. Ellwood Ave.	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		
Wilson		Auld		
5. SEX:	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday
Male	White	Married	Dec 5 1877	78 yrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country):	12. CITIZEN OF WHAT COUNTRY?
clerk		B.O.R.R. ret.	Md	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:		
Benjamin L Auld		Catharine		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS:		
		Mrs Mary Hessebaum Walther		
15. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
IMMEDIATE CAUSE (A)				5 yrs
ANTECEDENT CAUSE (S)				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				8 yrs
(B) arterio-sclerotic Cardio -				
DUE TO Vascular disease				
(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
0				
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from May 7, 1955, to Jan 29 1956, that I last saw the deceased alive on Jan 18, 1956 and that death occurred at 9:10 A.M. from the causes and on the date stated above.				
SIGNATURE		ADDRESS		DATE SIGNED
Joseph G. G. G.		423 Eastern Ave		1/29/56
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)
Burial		Greenmount		Balto
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS
1-30-56		C		Ullrich Funeral Home 4210 Belair Rd



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

<div style="text-align: center;"> <p>219</p> <p>MARYLAND STATE DEPARTMENT OF HEALTH</p> <p>2411 N. Charles Street, Baltimore</p> <p><b>CERTIFICATE OF DEATH</b></p> </div>				<div style="text-align: right;"> <p>00203</p> <p>Reg. Dist. No. <u>45</u></p> </div>	
<p>Medical Examiner's Certificate</p> <p>Items 13, 17: film G193 2-27-56 L</p>					
<p>1. PLACE OF DEATH- COUNTY <u>Baltimore</u></p>		<p>MARYLAND</p>		<p>2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u></p>	
<p>CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Middle River Md.</u></p>		<p>LENGTH OF STAY (in this place) <u>8 yrs</u></p>		<p>CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Middle River, Balto., 20 Md., 54</u></p>	
<p>HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>36 W. Midland Rd., Victory Villa</u></p>					
<p>3. NAME OF DECEASED (Type or Print) (First) <u>William A.</u> (Middle) <u>Badders</u> (Last) <u>Badders</u></p>		<p>4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>17</u> (Year) <u>1956</u></p>			
<p>5. SEX <u>male</u></p>	<p>6. COLOR OR RACE <u>white</u></p>	<p>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u></p>	<p>8. DATE OF BIRTH <u>May 3, 1909</u></p>	<p>9. AGE last birthday <u>46</u> yrs. If under 1 year: Months <u>  </u> Days <u>  </u> Hours <u>  </u> Mins. <u>  </u></p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u></p>		<p>10b. KIND OF BUSINESS OR INDUSTRY <u>Home Construction</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Pylesville, Md.</u></p>	
<p>12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u></p>		<p>13. FATHER'S NAME <u>William A. Badders</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Ida Shenberg/ Shanbarger</u></p>	
<p>15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>yes</u> <u>W II</u></p>		<p>16. SOCIAL SECURITY NO. <u>183-14-8404</u></p>		<p>17. INFORMANT AND ADDRESS <u>Orpha B. Badders, Middle River, Md.</u></p>	
<p>18. MEDICAL CERTIFICATION</p>					
<p>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</p> <p>Immediate cause (a) <u>Hypostatic pneumonia</u></p> <p>Antecedent cause(s) (b) <u>Pulmonary TBC</u></p> <p>(c) <u>  </u></p>				<p>INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> <u>6 yrs</u></p>	
<p>II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.</p>					
<p>19a. DATE OF OPERATION</p>		<p>19b. MAJOR FINDINGS OF OPERATION</p>		<p>20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/></p>	
<p>21. ACCIDENT (Specify) SUICIDE HOMICIDE</p>		<p>PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u></p>		<p>(CITY OR TOWN) (COUNTY) (STATE)</p>	
<p>TIME (Month) (Day) (Year) (Hour) OF INJURY</p>		<p>INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/></p>		<p>HOW DID INJURY OCCUR?</p>	
<p>22. I hereby certify that I attended the deceased from <u>inspected on 1-17</u>, 19<u>56</u>, to <u>6:30 AM</u>, 19<u>56</u>, that I last saw the deceased alive on <u>  </u>, 19<u>  </u>, and that death occurred at <u>  </u> m., from the causes and on the date stated above.</p>					
<p>SIGNATURE <u>Jack Collins, M.D. Parish Med Exam.</u></p>		<p>(Degree or title)</p>		<p>ADDRESS <u>Balt 22</u></p>	
<p>DATE SIGNED <u>1-17-56</u></p>					
<p>23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u></p>		<p>DATE THEREOF <u>Jan. 20, 1956</u></p>		<p>NAME OF CEMETERY OR CREMATORY <u>Cokesbury</u></p>	
<p>LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Md.</u></p>					
<p>24. FUNERAL DIRECTOR <u>Howard K. McComas &amp; Son, Abingdon, Md.</u></p>					
<p>DATE REC'D BY LOCAL REG. <u>1-24-56</u></p>		<p>REGISTRAR'S SIGNATURE <u>Edith Hursey</u></p>			

*Mr. [illegible]  
[illegible]  
[illegible]*

*[illegible]*

*[illegible]*

BUREAU V. S.

FEB 2 1956

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**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

# CERTIFICATE OF DEATH

00204

Reg. Dist. No. 38

220

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Towson</b>				TOWN <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>6508 Crestwood Road</b>				STREET ADDRESS (If rural give location) <b>6508 Crestwood Road #12</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Mr. Francis (Frank) X. Baird</b>				<b>4. DATE OF DEATH</b> (Month) <b>January</b> (Day) <b>1st</b> (Year) <b>1956</b>			
<b>5. SEX</b> <b>male</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>		<b>8. DATE OF BIRTH</b> <b>Oct. 8, 1886</b>	
				<b>9. AGE last birthday</b> <b>69</b> yrs.		<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Engineer, Heating &amp; Ventilating Co</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>New York</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>							
<b>13. FATHER'S NAME</b> <b>Mr. William J. Baird</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Ellen Walsh</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b> <b>216-01-3821</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Florence M. Baird, 6508 Crestwood</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>163X</b> IMMEDIATE CAUSE (A) <b>Terminal Stage Carcinoma Lungs.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>one year.</b>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>none</b>							
<b>19a. DATE OF OPERATION</b> <b>none</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)				<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from July 1955 to Jan 1, 1956, that I last saw the deceased alive on Dec 30, 1955, and that death occurred at 2:30 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Joseph F. Li Pin</b>				<b>ADDRESS</b> (Street, city, town, state) <b>8400 Loch Raven Blvd.</b>		<b>DATE SIGNED</b> <b>1-2-56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>				<b>DATE THEREOF</b> <b>Jan 4, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Mt. Maria Cemetery</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Jan 7, 1956</b>				<b>REGISTRAR'S SIGNATURE</b> <b>Mabel Gray</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>	

# CERTIFICATE OF DEATH

FILE NO.

1. NAME OF DECEASED

2. PLACE OF BIRTH

3. DATE OF BIRTH

4. SEX

5. OCCUPATION

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. DATE OF DEATH

10. TIME OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00205

38

221

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>55 TOWNS</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>TOWNS</b>		<b>55</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>00 8462 Loch Raven Blvd</b>				STREET ADDRESS (If rural give location) <b>8462 Loch Raven Blvd</b>		<b>1</b>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>Mrs. Elsie G. Banister</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>January 8th 19 56</b>			
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>W and D</b>	<b>8. DATE OF BIRTH</b> <b>Oct. 28, 1898</b>	<b>9. AGE last birthday</b> <b>57 yrs.</b>	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Sales Lady</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Valentine Hartman</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Beatrice K. Fiore, 8462 Loch Raven</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1</b> IMMEDIATE CAUSE (A) <b>Coronary artery thrombosis</b>							
ANTECEDENT CAUSE(S) DUE TO (B) <b>Hypertensive Cardio vascular disease</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1/5, 1956, to 1/8, 1956, that I last saw the deceased alive on 1/8, 1956, and that death occurred at 8:24 A.M. from the causes and on the date stated above. 1/9/56</b>							
<b>SIGNATURE</b> <i>Gordon Graw</i>				<b>ADDRESS</b> (Street, city, town, state) <b>85 v 3 Loch Raven Blvd Towson Md</b>			
<b>DATE</b> <b>JAN 12 1956</b>				<b>DATE SIGNED</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Jan. 11, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cem.</b>		<b>LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Mabel Gray</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>			

# CERTIFICATE OF DEATH

221

Reg. Gen. No.

1. Usual Residence

2. Place of Death

3. Date of Death

4. Cause of Death

5. Manner of Death

6. Age at Death

7. Sex

8. Race

9. Marital Status

10. Occupation

11. Education

12. Date of Birth

13. Place of Birth

14. Date of Admission

15. Date of Discharge

16. Date of Death

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

#B: film G192 2-21-56 L : 222

00206

Reg. Dist.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Catonsville</u>		LENGTH OF STAY (In this place) <u>2YRS.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>720 Meadowbrook Road</u>				STREET ADDRESS (If rural, give location) <u>720 Meadowbrook Road</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>DAVID AUGUSTUS BARTH</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1 22 19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Sept. 19, 1892</u>	9. AGE last birthday: <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Glue Factory</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>John Barth</u>				14. MOTHER'S MAIDEN NAME: <u>Mary M. Wolbert</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY No.: <u>219-12-8278</u>		17. INFORMANT & ADDRESS: <u>George H. Barth 720 Meadowbrook Road Catonsville 28, Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<p>322.0 Immediate cause (a)..... DUE TO Antecedent cause(s) (b)..... DISEASES OR CONDITIONS, IF ANY, giving rise to the above cause DUE TO stating underlying cause last (c)..... DEATH IS DUE TO NATURAL CAUSES</p>							
2. INTERVAL BETWEEN ONSET AND DEATH							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>W. E. Harry</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>1/23/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>Jan. 25/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Jennings Chapel Cemetery</u>		LOCATION (City, town, or county) (State): <u>Howard County, Maryland.</u>	
DATE REC'D BY LOCAL REG. <u>1/24/56</u>		REGISTRAR'S SIGNATURE <u>W. E. Harry</u>		24. FUNERAL DIRECTOR <u>Easton Sons, Catonsville 28, Md.</u>		ADDRESS	

BUREAU V. S.

JAN 26, 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 155 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

0020730

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Baltimore</u>	STATE <u>Md.</u>	COUNTY <u>Bald</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>CATONSVILLE</u>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hood Conv. Home</u>	STREET ADDRESS (If rural give location) <u>1</u>		
3. NAME OF DECEASED (Type or Print) <u>Clarance W. Bathgate</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>5</u> (Year) <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH <u>12-6-79</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DAVIDSON</u>	11. BIRTHPLACE (State or foreign country) <u>Md.</u>
13. FATHER'S NAME <u>Charles</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Mullineaux</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>Family - Same</u>	
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
450.1 IMMEDIATE CAUSE (A) <u>Pneumonia - R Leg -</u>			3-days
ANTECEDENT CAUSE(S) DUE TO (B) <u>Generalized arteriosclerosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u></u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u></u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)	
21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>DEC 31, 1955</u> to <u>JAN 5, 1956</u> , that I last saw the deceased alive on <u>JAN 5, 1956</u> , and that death occurred at <u>2:45 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James H. Howell</u>		ADDRESS (Street, city, town, state) <u>Catonville</u>	
DATE SIGNED <u>1-6-</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>	DATE THEREOF <u>1/9/56</u>	NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL</u>	LOCATION (City, town, or county) (State) <u>BH 110</u>
24. REC'D BY REGISTRAR <u>JAN 10 1956</u>	REGISTRAR'S SIGNATURE <u>V. E. Dwyer</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>McCollig Funeral Home</u>	ADDRESS

# CERTIFICATE OF DEATH

Form 101-1-1

1. NAME OF DECEASED

2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. MARITAL STATUS  
8. EDUCATION  
9. RELIGION  
10. RACE  
11. COLOR  
12. ETHNIC ORIGIN  
13. SOCIAL CLASS  
14. INCOME  
15. HEALTH STATUS  
16. PREVIOUS ILLNESS  
17. CAUSE OF DEATH  
18. MANNER OF DEATH  
19. PLACE OF DEATH  
20. TIME OF DEATH  
21. SIGNATURE OF PHYSICIAN  
22. SIGNATURE OF REGISTRAR  
23. SIGNATURE OF WITNESS  
24. SIGNATURE OF DECEASED  
25. SIGNATURE OF NEXT OF KIN  
26. SIGNATURE OF CLERGYMAN  
27. SIGNATURE OF CHURCH  
28. SIGNATURE OF FUNERAL HOME  
29. SIGNATURE OF BURIAL PLACE  
30. SIGNATURE OF INTERMENT PLACE  
31. SIGNATURE OF CREMATION PLACE  
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BUREAU V. S.

JAN 11 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

Items 13, 14, Film 192 2-3-56 et

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

00208

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesaco Park</u> TOWN <u>Chesaco Park</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Patapsco Ave</u>		STATE <u>md</u> COUNTY <u>Balto</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chesaco Park</u> OR TOWN <u>Chesaco Park</u> STREET ADDRESS (If rural give location) <u>Patapsco Ave</u>	
3. NAME OF DECEASED: (Type or Print) <u>ANNE Maria Bengel</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan 28 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>W.H.T.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>	8. DATE OF BIRTH: <u>Nov 20 - 1870</u>
9. AGE last birthday: <u>85 yrs.</u>		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife At Home</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Balto md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>William Webb</u>		14. MOTHER'S MAIDEN NAME: <u>Mary Weich</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>None</u>		16. SOCIAL SECURITY NO.: <u>None</u>	
17. INFORMANT & ADDRESS: <u>J. Morris Betz 2830 Pelham Ave</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>			<u>2 hours</u>
DUE TO			
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. TIME (Month) (Day) (Year) (Hour) OF INJURY		21F. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work	
22. I hereby certify that I <u>inspected</u> the deceased from <u>19</u> , to <u>19</u> , that I last saw the deceased alive on <u>19</u> , and that death occurred at <u>2:35 PM</u> M, from the causes and on the date stated above.			
SIGNATURE <u>John Hollen M.D. dep. medical examiner</u>		ADDRESS <u>Belt</u> DATE SIGNED <u>22 1 20-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/31/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		LOCATION (City, town, or county) <u>Balto.</u> (State) <u>md.</u>	
24. FUNERAL DIRECTOR		ADDRESS	
REGISTRAR <u>30 56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Lassahn Funeral Home 7401 Belair Rd.</u>	

Dr. Joact Collins 9-1<sup>30</sup> A.M.  
2Husship Rd  
Dundolt



225  
CERTIFICATE OF DEATH

Reg. Dist. No. 40

Items 11 12 Film G191 1-16-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		STATE <u>MD.</u> COUNTY <u>BALTO.</u>		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>White Marsh</u>		LENGTH OF STAY (in this place)		CITY OR TOWN <u>BALTO.</u>		CITY OR TOWN <u>3rd-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 Aberdeen Ave</u>				STREET ADDRESS (If rural give location) <u>1613 Elm St</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Berita</u> (Middle) <u>Benie</u> (Last)				4. DATE OF DEATH (Month) <u>1-9</u> (Day) <u>19</u> (Year) <u>56</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>W</u>	8. DATE OF BIRTH <u>-1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Lithuania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>?</u>				14. MOTHER'S MAIDEN NAME <u>?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Family - Same</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>uremia</u>						2 wks.	
DUE TO ANTECEDENT CAUSE(S) (B) <u>Nephrosclerosis</u>						1 yr.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arteriosclerotic Cardiovascular</u>						2 yrs	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1 1953</u> to <u>Jan 9 1956</u> that I last saw the deceased alive on <u>Jan 9 1956</u> , and that death occurred at <u>7 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Walter Hemmetts</u>				ADDRESS (Street, city, town, state) <u>8552 Phyllis Rd Balto</u>		DATE SIGNED <u>1/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>B</u>		DATE THEREOF <u>1-13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) (State) <u>BALTO.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. Walter Hemmetts</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>William J. Jones</u>		ADDRESS <u>Home</u>	

VS A15C 1-55 10M

## INSTRUCTIONS

1

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

CERTIFICATE OF DEATH

823

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

IMMEDIATE CAUSE OF DEATH

INTERMEDIATE CAUSE OF DEATH

UNDERLYING CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

2 weeks  
1 yr.  
2 yrs

Outbreak of  
Typhoid fever  
in  
Baltimore

BUREAU V. S.

JAN 12 1956

RECEIVED  
JAN 12 1956

Jan 12 1956  
8555  
JAN 12 1956

Jan 12 1956  
8555  
JAN 12 1956



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00210

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 TOWN BALTIMORE</u>		LENGTH OF STAY (in this place) <u>12-19-56/1/19/56</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>BALTIMORE</u> <u>3Y01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 SPRING GROVE STATE HOSP.</u>				STREET ADDRESS (If rural give location) <u>129 S. LOUDON AV. BALTO. 10 - MD.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>HORACE</u> <u>B</u> <u>BEREAN</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>19</u> <u>1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>	8. DATE OF BIRTH: <u>8-8-72</u>	9. AGE last birthday: <u>83</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>INSURANCE AGENT</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Travelers Ins. Co.</u>		11. BIRTHPLACE (State or foreign country): <u>PENN.</u>	
13. FATHER'S NAME: <u>SAMUEL BEREAN</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unk.</u>				16. SOCIAL SECURITY NO.: <u>unk.</u>		17. INFORMANT & ADDRESS: <u>HORACE BEREAN JR.</u> <u>300 GOODWOOD GARDENS - BALTO. 10 MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>450.0</u>						<u>5 HOURS</u>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>CARDIAC FAILURE</u>							
DUE TO							
(B) <u>GENERALIZED ARTERIOSCLEROSIS</u>							
DUE TO							
(C) <u>ADVANCED AGE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/19/1955</u> to <u>1/19/1956</u> , that I last saw the deceased alive on <u>1/19/1956</u> , 19 <u>56</u> , and that death occurred at <u>10:50 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Stella Wachol</u>		DATE SIGNED <u>January 21, 1956</u>		ADDRESS <u>M. D. Schimmek Funeral Home, Inc.</u> <u>2601-3-5 E. Madison St.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Cremation</u>		DATE THEREOF <u>1/21/56</u>		NAME OF CEMETERY OR CREMATORY <u>Greenmount Crematory</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>January 21, 1956</u>		REGISTRAR'S SIGNATURE <u>R.W.</u>		24. FUNERAL DIRECTOR <u>Schimmek Funeral Home, Inc.</u>		ADDRESS <u>2601-3-5 E. Madison St.</u>	



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## CERTIFICATE OF DEATH

Reg. Dist. No.

30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>52 Catonsville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	<b>3V01-4</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>90 House-in-the-Pines</b>		STREET ADDRESS (If rural give location) <b>28 Augusta Ave.</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>MARGARET I. BOEHNE</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>Jan. 15, 1956</b>	
5. SEX: <b>female</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>widowed</b>	8. DATE OF BIRTH: <b>Oct. 28, 1877</b>
9. AGE last birthday: <b>78</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>at home</b>	
11. BIRTHPLACE (State or foreign country): <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Augustus Hirsch</b>		14. MOTHER'S MAIDEN NAME: <b>Anna Mary Foster</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>no</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <b>Mr. John F. L. Boehne, Jr.-413 Warren Ave.</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>332X</b>		<b>1</b>	
ANTECEDENT CAUSE (S) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		<b>4 days</b>	
(A) <b>Pulmonary Defect</b>			
(B) <b>Cerebral Thrombosis</b>			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1/11</b> , 19 <b>56</b> , to <b>1/15</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1/15</b> , 19 <b>56</b> , and that death occurred at <b>6 P.</b> M, from the causes and on the date stated above.			
SIGNATURE <b>Samuel L. Kohnberger</b>		DATE SIGNED <b>1/16/56</b>	
M. D. <b>4/23</b>		<b>Frederick A. Bost</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1.18/56</b>	
NAME OF CEMETERY OR CREMATORY <b>Western Cem.</b>		LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
DATE, REC'D BY LOCAL REGISTRAR <b>1-16-56</b>		REGISTRAR'S SIGNATURE <b>Frederick A. Bost</b>	
24. FUNERAL DIRECTOR <b>Wm. J. Kohnberger &amp; Sons</b>		ADDRESS <b>Balto 17 Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

00212

2411 N. Charles Street, Baltimore

228

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH- COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Gray Manor</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>2414 Plainfield Avenue</b>		STREET ADDRESS (If rural, give location) <b>2414 Plainfield Avenue</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>Margaret Bowers</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>January 8 1956</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Widow</b>	8. DATE OF BIRTH <b>March 4, 1873</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	9. AGE last birthday <b>82</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jacob Lightner</b>		14. MOTHER'S MAIDEN NAME <b>Magdalen</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <b>Mrs Elizabeth Rossback 2414 Plainfield Av</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <b>Pulmonary edema, acute</b>		<b>30 mins.</b>
Antecedent cause(s) (b) <b>Hiatus hernia</b>		<b>undet.</b>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <b>Arteriosclerosis, generalized.</b>		<b>undet.</b>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <b>Diabetes</b>		<b>undet.</b>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) SUICIDE HOMICIDE	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **Dec 15, 1955**, to **Jan 8, 1956**, that I last saw the deceased alive on **Jan 7, 1956**, and that death occurred at **.....** m., from the causes and on the date stated above.

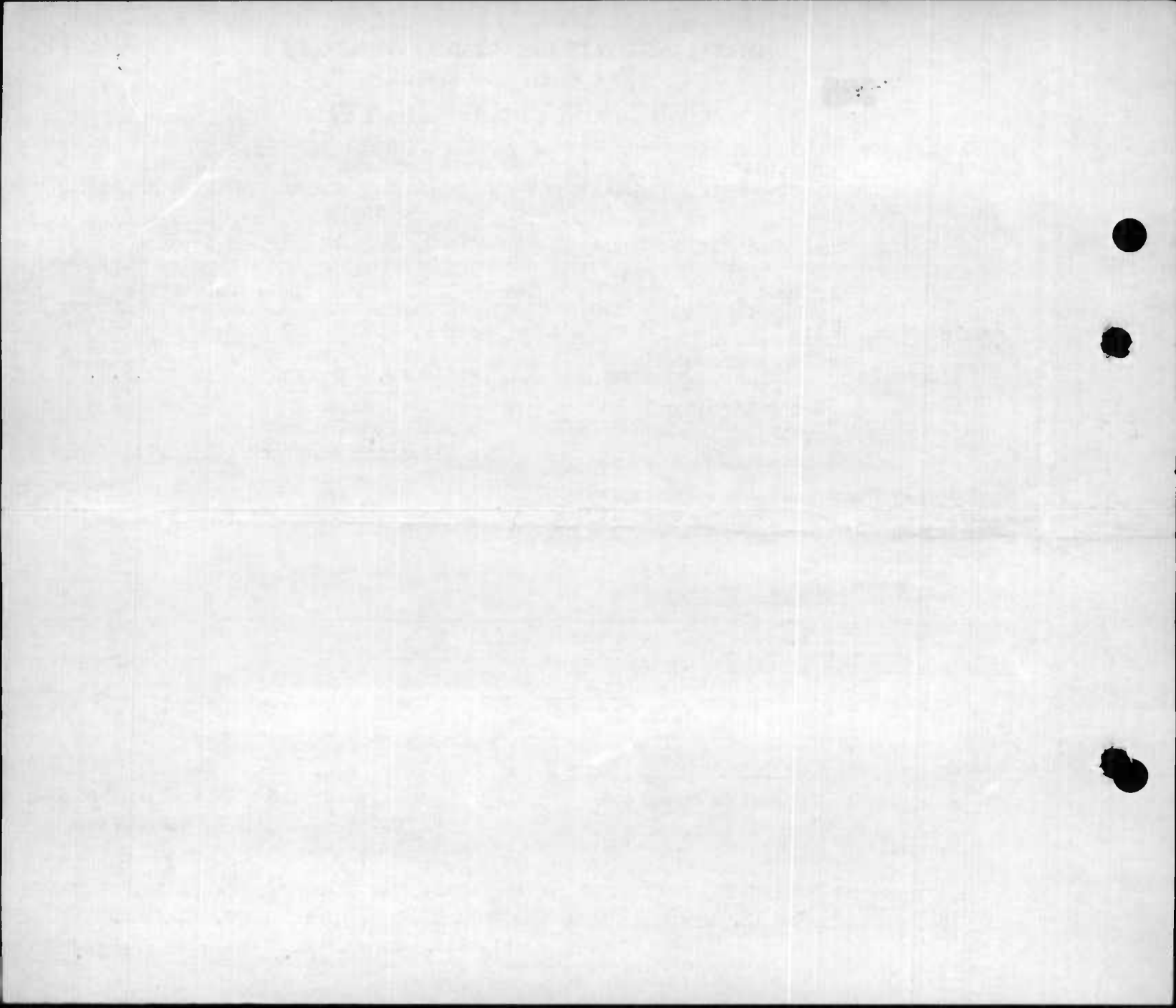
SIGNATURE **D. Blatt, MD** (Degree or title) ADDRESS **434 Eastern Ave. East. Md** DATE SIGNED **1/9/56**

23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>Jan 12, 1956</b>	NAME OF CEMETERY OR CREMATORY <b>Sacred Heart</b>	LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
DATE REC'D BY LOCAL REG. <b>1-12-56</b>	REGISTRAR'S SIGNATURE <b>[Signature]</b>	24. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</b>	ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

229

## CERTIFICATE OF DEATH

00213

38

Reg. Dist. No. ....

Items 8,9 FilmGL92 2-20-56 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>		LENGTH OF STAY (in this place) <u>life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8201 Pleasant Plains Road</u>				STREET ADDRESS (If rural give location) <u>8201 Pleasant Plains Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>MARY ELLEN BOWERS</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>January 12th, 19 56</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>		8. DATE OF BIRTH <u>March 22, 1880</u>	
9. AGE last birthday <u>76</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housework</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore County, Md.</u>	
13. FATHER'S NAME <u>Bernard Bowers</u>				14. MOTHER'S MAIDEN NAME <u>Annie Carter</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Miss Mae Bowers, 8201 Pleasant Plains Rd.</u>	
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Am. Arteriosclerosis</u>						<u>1 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes mellitus</u>						<u>1 yr</u>	
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 1, 1954</u> , to <u>Jan 12, 1956</u> , that I last saw the deceased alive on <u>Jan 10, 1956</u> , and that death occurred at <u>10 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>George Sawyer</u>				ADDRESS (Street, city, town, state) <u>4808 Harford Rd.</u>		DATE SIGNED <u>1/13/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Wilson Methodist Cemetery</u>		LOCATION (City, town, or county) (State) <u>Long Green, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Michael Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence Funeral Home</u>		ADDRESS <u>7401 Belair Road</u>	
DATE <u>JAN 16 1956</u>							

AN I 9 MAY 1956

RECEIVED



230

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00214

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
TOWN <u>Catonsville</u>				STREET ADDRESS (If rural give location) <u>924 N. Caroline Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>16 Fusting Avenue</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 6, 1956</u>			
(Type or Print) <u>AUGUSTA G. BRANDAU</u>							
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>Feb. 4, 1872</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>		11. BIRTHPLACE (State or foreign country): <u>Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>----</u>				14. MOTHER'S MAIDEN NAME: <u>----</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>----</u>				16. SOCIAL SECURITY NO. <u>----</u>		17. INFORMANT & ADDRESS: <u>Howell C. Brown, 5030 Edgar Terrace</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>442X</u>							
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Myocardial Decompensation</u>							<u>12 hrs</u>
DUE TO							
(B) <u>Chronic Hypertensive C. V. B. Disease</u>							<u>10 yrs (?)</u>
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County)	(State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11-3</u> , 1951, to <u>1-6</u> , 1956, that I last saw the deceased alive on <u>1-5</u> , 1956, and that death occurred at <u>6 A.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>William K. Gallagher</u>		ADDRESS <u>M. D. Catonsville-28, Md.</u>		DATE SIGNED <u>1/6/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>6 56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDER

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00215

231

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH COUNTY <b>BALTIMORE</b> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b> TOWN <b>101 DAYS</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MARYLAND</b> COUNTY <b>ANNE ARUNDEL</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>PASADENA</b> TOWN <b>PASADENA</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>RT. # 2 BOX 23</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>ELMER BRENNEMAN</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>JANUARY 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Divorced</b>	8. DATE OF BIRTH <b>April 10, 1900</b>	9. AGE last birthday <b>55</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (State or foreign country) <b>Pasadena, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William T. Breneman</b>				14. MOTHER'S MAIDEN NAME <b>Sadie E. MN: Thomas</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b> <b>WW II</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>216-16-4204</b>		17. INFORMANT & ADDRESS <b>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>421.1</b> IMMEDIATE CAUSE (A) <b>AORTIC INSUFFICIENCY</b>						UNKNOWN	
ANTECEDENT CAUSE(S) DUE TO <b>HEALED ENDOCARDITIS, AORTIC VALVE</b>						UNKNOWN	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>PULMONARY EDEMA</b>						1 DAY	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Oct. 10, 1955</b> to <b>Jan. 19, 1956</b> and that death occurred at <b>11:15 PM</b> from the causes and on the date stated above.							
SIGNATURE <b>Donald D. Mark</b> M.D.				DATE SIGNED <b>1/20/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1-23-56</b>		NAME OF CEMETERY OR CREMATORY <b>Oak Lawn Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
24. REC'D BY REGISTRAR <b>Jan. 23, 1956</b>		REGISTRAR'S SIGNATURE <b>Dwison L. Larley</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight, Inc.</b> ADDRESS <b>6009 Harford Rd. Balto. Md.</b>			

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, place of death, cause of death, and physician's signature.

BUREAU V. S.

JAN 24 1935

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

00216

232

1. PLACE OF DEATH- COUNTY <u>BALTO.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MD</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SORENSEN NURSING HOME 7912 RUXLEY RD</u>		STREET ADDRESS (If rural, give location) <u>8004 OAKLEIGH RD</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>CHARLES</u> (Middle) <u>LEO</u> (Last) <u>BROOKS</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1-15-1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>11-23-1892</u> 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>PA. NR.</u>	11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>
13. FATHER'S NAME <u>SHADRICK BROOKS</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE POWD</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY No. <u>717-07-7753</u>	
17. INFORMANTS <u>CHARLES L. BROOKS JR. 1722 FORRESTA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a) Coronary Thrombosis

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Hypertension & arteriosclerosis for years(c) Nephritis, chronic interstitial?

INTERVAL BETWEEN ONSET AND DEATH

II. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>INJURY</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	(CITY OR TOWN) <u>BALTO.</u>	(COUNTY) <u>MD</u>	(STATE) <u>MD</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>12-3-55</u>	INJURY OCCURRED While at Work <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>1-15-56</u>		

22. I hereby certify that I attended the deceased from 12-3-55, to 1-15-56, that I last saw the deceasedlive on 1-14-56, and that death occurred at 6 A m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>1-18-1956</u>	NAME OF CEMETERY OR CREMATORY <u>MORELAND MEMORIAL</u>	LOCATION (City, town, or county) <u>BALTO. Co.</u>	(State) <u>MD</u>
DATE REC'D BY LOCAL REG. <u>76 36</u>	REGISTRAR'S SIGNATURE <u>Edna H. Conklin</u>	24. FUNERAL DIRECTOR <u>Edna H. Conklin</u>	ADDRESS <u>5444 BELMONT RD</u>	







Oliver; Margaret; Mr. S. M. S. - 1781-1856

County

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

204

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

00218

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: 1818 Winans Avenue  
 County Balto.  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Halethorpe  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State MD. County Balto  
 City or town Halethorpe  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1818 Winans Avenue 51  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war

## 3. (a) FULL NAME

MARY R. BRYAN

## 3. (b) Social Security Number

NONE

4. Sex FEMALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced WIDOWED  
 6. (b) Name of husband or wife Augustus Ward  
 6. (c) If alive, give age Dec. years

7. Birth date of deceased (mo., day, yr.) July 10-1876  
 8. AGE: Years 79 Months Days It less than one day  
 hrs. min.

9. Birthplace London Co. Virginia  
 (Town, county, and state)  
 10. Usual occupation Housewife

11. Industry or business  
 12. Name Arthur Green  
 13. Birthplace Unknown  
 14. Maiden name Marion  
 15. Birthplace

16. Informant Shelma Bany  
 Address 1818 Winans Way  
 17. Burial Date thereof July 27 1956  
 (Burial, cremation, or removal Which?) (month) (day) (year)  
 Cemetery or crematory Washington Mem. Pk.  
 Location Dells Church Va.  
 18. Funeral director Wm Cook Inc  
 Address 1519 St Paul St

19. 1/25/56 19 56  
 (Date rec'd by registrar) Registrar A. W. Hedrich

## MEDICAL CERTIFICATION

20. DATE OF DEATH JANUARY 24 19 56 at 10 30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1953 19 53 to 1/24 19 56  
 and that I last saw him alive on 1/23 19 56

Immediate cause of death Myocardial Infarction  
Arterio Sclerotic C.V.D.

## DURATION

Due to 443X

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE John C. Tracy M.D.  
 M.D. or other  
 Address Halethorpe, Md. Date signed 1/24/56

CERTIFICATE OF DEATH

1. Name of deceased

2. Age

3. Sex

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Signature of witness

10. Signature of coroner

11. Signature of jury

12. Signature of jury

13. Signature of jury

14. Signature of jury

15. Signature of jury

16. Signature of jury

17. Signature of jury

18. Signature of jury

19. Signature of jury

20. Signature of jury

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00219  
Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u> ✓	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Ms. Loch Raven</u>				TOWN <u>Baltimore</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Md. Training School for Boys</u>				STREET ADDRESS (If rural, give location) <u>1018 William Street</u>			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
(Type or Print) <u>Lowell</u>		<u>Franklin</u>		<u>Chapman</u>		<u>1</u> <u>11</u> <u>19</u> <u>56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Sing.</u>	<u>4/29/41</u>	<u>11</u> yrs.		Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>School</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Letcher F. Chapman</u>				14. MOTHER'S MAIDEN NAME: <u>Hazel Collins</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>Mr. Letcher Chapman 117 N. Front St.</u>			
(If Yes, give war or dates of service)							
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
434.3 Immediate cause (a) <u>Idiopathic Myocardial Hypertrophy and Fibrosis</u>							
DUE TO							
Antecedent cause(s) (b) <u>DUE TO</u>							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Paul F. Men</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>1/12/56</u>	
		M. D.		ASSISTANT MEDICAL EXAM.			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>1/15/56</u>		NAME OF CEMETERY OR CREMATORY <u>LaFollette</u>		LOCATION (City, town, or county) (State) <u>LaFollette, Tenn</u>	
DATE REC'D BY LOCAL REG. <u>1/13/56</u>		REGISTRAR'S SIGNATURE <u>G. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>JOHN F. DENNY, INC.</u>		ADDRESS <u>715 Light St.</u>	

# STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS

NAME OF DECEASED: \_\_\_\_\_ SEX: \_\_\_\_\_ AGE: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_ PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

PLACE OF BIRTH: \_\_\_\_\_

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PLACE OF BIRTH: \_\_\_\_\_



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00220

234

## CERTIFICATE OF DEATH

Reg. Dist. No. 457

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Baltimore 34, Loch Raven</u>		<u>life</u>		TOWN <u>Baltimore 34, Loch Raven</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Lake Drive</u>				STREET ADDRESS (If rural give location) <u>Lake Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>John Herbert</u> (Middle) <u>Chenowith</u> (Last)				(Month) <u>1-7-56</u> (Day) <u>19</u> (Year)			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>married</u>	<u>4-30-1899</u>	<u>56</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>truck driver</u>		<u>Balto. City Water</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>John T. Chenowith</u>				14. MOTHER'S MAIDEN NAME <u>Louisa Francis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Balto. 34, Md. Mrs. Mary E. Chenowith, Lake Dr.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
434.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>1 day</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac Disease</u>						<u>8 yrs</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> et work <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 7, 1956</u> to <u>Jan 8, 1956</u> that I last saw the deceased alive on <u>Jan 7, 1956</u> , and that death occurred at <u>5:30</u> M. from the causes and on the date stated above.							
SIGNATURE <u>Walter H. Hammett</u>		ADDRESS (Street, city, town, state) <u>M.D. Baltimore</u>		DATE SIGNED <u>1-9-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-10-56</u>		NAME OF CEMETERY OR CREMATORY <u>Jessops Methodist</u>		LOCATION (City, town, or county) (State) <u>Sparks, Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 16 1956</u>		REGISTRAR'S SIGNATURE <u>Walter H. Hammett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>L. Scott Brooke</u>		ADDRESS <u>Sparks, Md.</u>	

100830

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

# CERTIFICATE OF DEATH

284

Reg. No. 100

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Print or write full name)

9. Place of death (City, State, Country)

10. Signature of physician (Print or write full name)

11. Signature of registrar (Print or write full name)

12. Signature of coroner (Print or write full name)

13. Signature of undertaker (Print or write full name)

14. Signature of funeral home (Print or write full name)

15. Signature of cemetery (Print or write full name)

16. Signature of church (Print or write full name)

17. Signature of family (Print or write full name)

18. Signature of friends (Print or write full name)

19. Signature of neighbors (Print or write full name)

20. Signature of community (Print or write full name)

21. Signature of state (Print or write full name)

22. Signature of federal government (Print or write full name)

23. Signature of international community (Print or write full name)

24. Signature of world (Print or write full name)

25. Signature of universe (Print or write full name)

26. Signature of everything (Print or write full name)

27. Signature of nothing (Print or write full name)

28. Signature of everything and nothing (Print or write full name)

29. Signature of the end (Print or write full name)

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Print or write full name)

9. Place of death (City, State, Country)

10. Signature of physician (Print or write full name)

11. Signature of registrar (Print or write full name)

12. Signature of coroner (Print or write full name)

13. Signature of undertaker (Print or write full name)

14. Signature of funeral home (Print or write full name)

15. Signature of cemetery (Print or write full name)

16. Signature of church (Print or write full name)

17. Signature of family (Print or write full name)

18. Signature of friends (Print or write full name)

19. Signature of neighbors (Print or write full name)

20. Signature of community (Print or write full name)

21. Signature of state (Print or write full name)

22. Signature of federal government (Print or write full name)

23. Signature of international community (Print or write full name)

24. Signature of world (Print or write full name)

25. Signature of universe (Print or write full name)

26. Signature of everything (Print or write full name)

27. Signature of nothing (Print or write full name)

28. Signature of everything and nothing (Print or write full name)

BUREAU V. S.

JAN 16 1950

RECEIVED

*Handwritten signature and notes*

INSTRUCTIONS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00221  
 CERTIFICATE OF DEATH

Reg. Dist. No. 43

235

1. PLACE OF DEATH:

COUNTY Balto. MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Essex LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Balto  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Essex  
 STREET ADDRESS (If rural, give location) 276 Montrose Ave.

3. NAME OF DECEASED:

(First) ESTHER (Middle) J. (Last) CLARK

4. DATE OF DEATH:

(Month) (Day) (Year) 1-4-1956

5. SEX:

F.

6. COLOR OR RACE:

W

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

WIDOW

8. DATE OF BIRTH:

6-25-1899

9. AGE last birthday:

56 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

House-keeper at home

10b. KIND OF BUSINESS OR INDUSTRY:

New Jersey

11. BIRTHPLACE (State or foreign country):

U.S.A.

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME:

Dudley Van Blarcom

14. MOTHER'S MAIDEN NAME:

Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

No

16. SOCIAL SECURITY No.:

Unknown

17. INFORMANT & ADDRESS:

Irene Kidd (same)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

420.0

Immediate cause

(a) DUE TO

acute cardiac decompensation

INTERVAL BETWEEN ONSET AND DEATH

5 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

arterio-sclerotic heart disease

6 yrs

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

21. ACCIDENT SUICIDE HOMICIDE (Specify)

TIME (Month) (Day) (Year) (Hour) OF INJURY

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from April 1950 to Jan 1, 1956, that I last saw the deceased alive on Jan 3, 1956 and that death occurred at 2:45 P.M. from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify):

Burial  
 DATE REC'D BY LOCAL REG. 1-9-56

DATE THEREOF

1-9-56

NAME OF CEMETERY OR CREMATORY

Belair Memorial

LOCATION (City, town, or county)

Belair

(State)

Md.

24. FUNERAL DIRECTOR

John G. Connelly, Essex Md.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

BUREAU V. S.

JAN 17 1956

RECEIVED

236

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Underwood LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS  
90 Brenson Nursing Home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR TOWN Baltimore City 3601-4  
 STREET ADDRESS (If rural, give location)  
3365 Chestnut Ave

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

JOSEPH

CLARK

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

1 - 10 1956

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

Male

White

Single

1-24-1877

78

yrs. II 17

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

No

—

3365 Caroline F Daniels Chestnut Ave

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

4222

Immediate cause

DUE TO

Cerebral accident (second hemorrhage)

5 days

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

Myocarditis chronic

5 years

(c)

Myocardial hypertrophy

5 years

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

Prostate hypertrophy

10 yrs.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

ante Dec 55

Prostate removal at Sinai Hospital

Yes ☐ No ☐

## 21. ACCIDENT

(Specify)

PLACE (Home, farm, factory, street, OF office bldg, etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

SUICIDE

Natural

INJURY

no injury.

no injury.

TIME (Month) (Day) (Year) (Hour)

OF INJURY

no injury

M.

HOW DID INJURY OCCUR?

no injury

While at work

Not while at work

no injury

no injury

22. I hereby certify that I attended the deceased from I-1-55, to I-10-56, 19....., that I last saw the deceasedalive on I-5th-, 19....., and that death occurred at II-50A m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

James Graham Munton M.D.516 Cathedral StreetI-II-56

## 23. BURIAL, CREMATION REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REG.

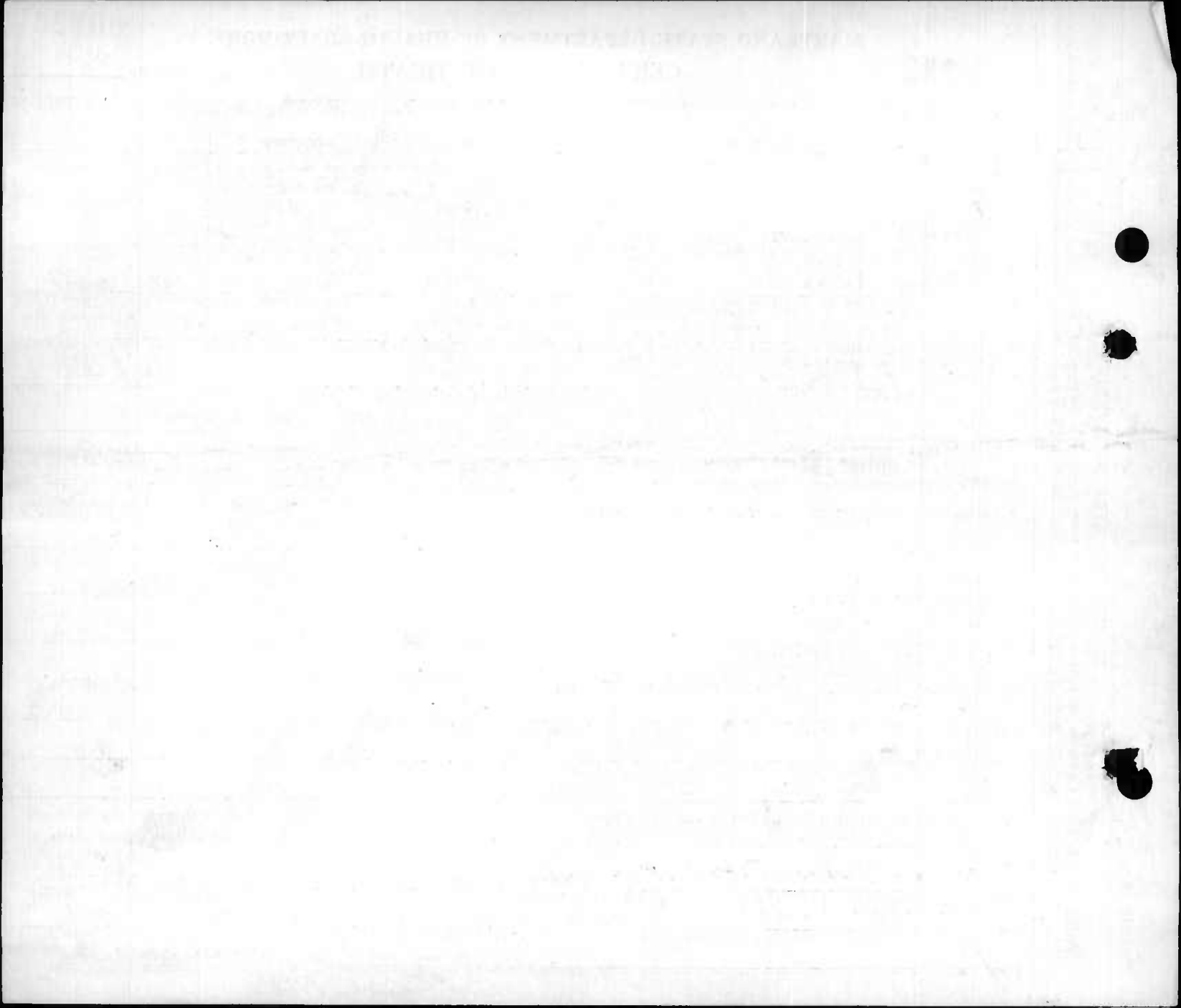
## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS.

11/2/55A.W. HedrickFrank W Seitz814 W 36th St.Baltimore Md.

MARGIN RESERVED FOR BINDING





1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

237

## CERTIFICATE OF DEATH

00223

Reg. Dist. No. 45

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Victory Villa</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Victory Villa</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 E. Hickham Road</u>				STREET ADDRESS (If rural give location) <u>19 E. Hickham Road</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>WANDA</u> <u>RAE</u> <u>CLARKE</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Jan. 2, 1956</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Single</u>	<b>8. DATE OF BIRTH</b> <u>May 19, 1955</u>	<b>9. AGE last birthday</b> yrs. <u>7</u>	<b>IF UNDER 1 YEAR</b> Months <u>13</u>	<b>IF UNDER 24 HRS.</b> Hours <u>13</u> Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore, Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Lloyd Harlan Clarke</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Luverna G. McGinnis</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Lloyd Harlan Clarke 19 E. Hickham Road</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>752X IMMEDIATE CAUSE (A)</b> <u>Aspiration pneumonia</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Hydrocephalus and meningitis, congested</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>October 3, 1955</u>, to <u>January 2, 1956</u>, that I last saw the deceased alive on <u>January 2, 1956</u>, and that death occurred at <u>3:55</u> M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>George D. Edwards</u>				<b>DATE SIGNED</b> <u>January 2, 1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Removal</u>		<b>DATE THEREOF</b> <u>Jan. 3, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Pleasant Hill Cem.</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Morgantown, W. Va.</u>	
<b>24. RECEIVED BY REGISTRAR</b> <u>JAN 4 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. Edith Hurley</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William Cook, Inc. 1217 St. Paul Street</u>			

90000000X-V



Item 2 by phone to Augsburg Home 1-12-56 ams

## CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

238

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>30014</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springthorn Hosp</u>		STREET ADDRESS (If rural, give location) <u>6811 Campfield Rd</u>	
3. NAME OF DECEASED (Type or Print) <u>Elizabeth Class</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>8</u> (Year) <u>56</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Not Known</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTH PLACE (State or foreign country) <u>Not Known</u>	
13. FATHER'S NAME <u>Not Known</u>		14. MOTHER'S MAIDEN NAME <u>Not Known</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Not Known</u>	
17. INFORMANT AND ADDRESS <u>W. Katenkamp 6811 Campfield Rd</u>		12. CITIZEN OF WHAT COUNTRY <u>Not Known</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

(a)

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Nov 29 55 m.INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

SIGNATURE

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

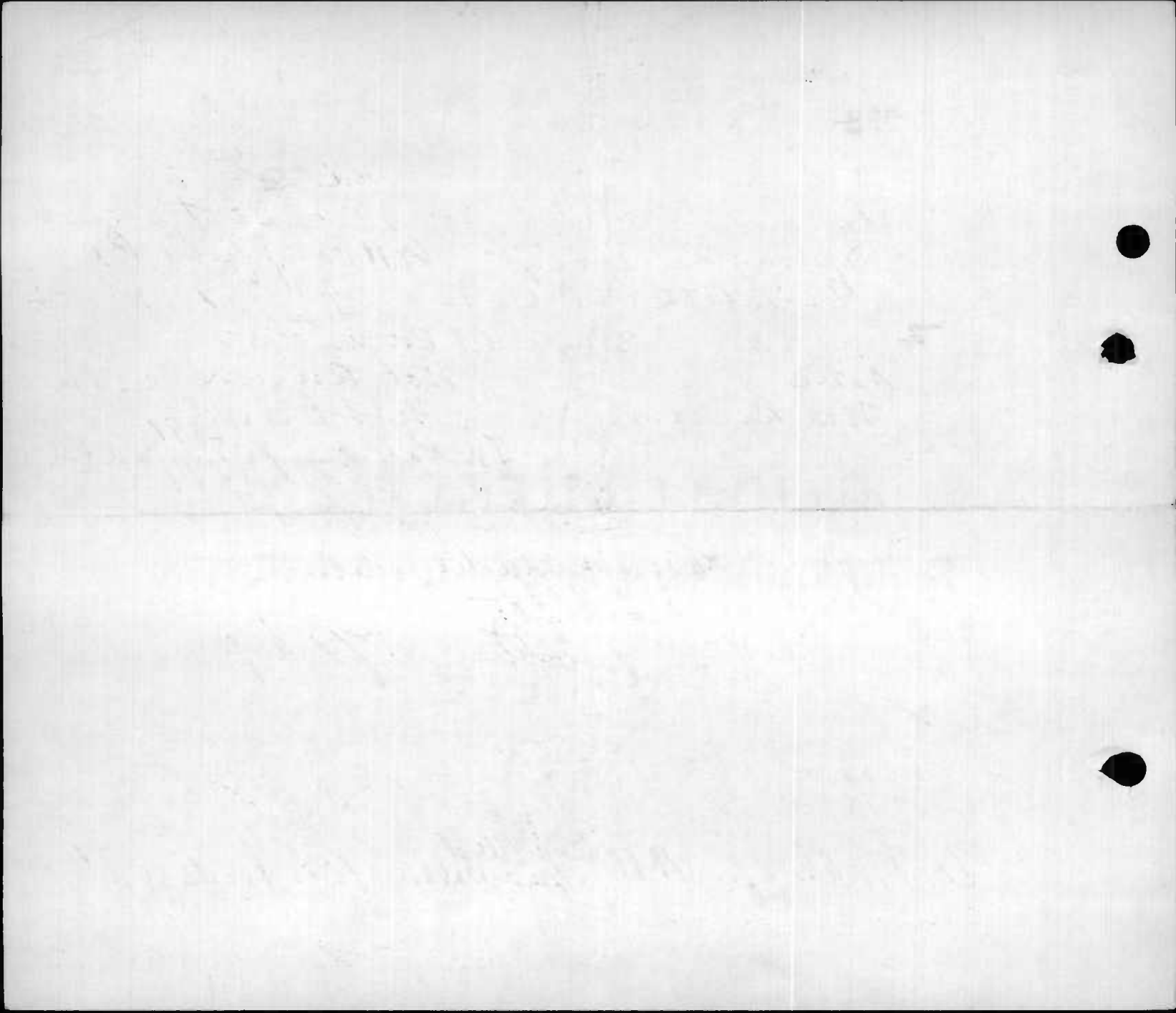
REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

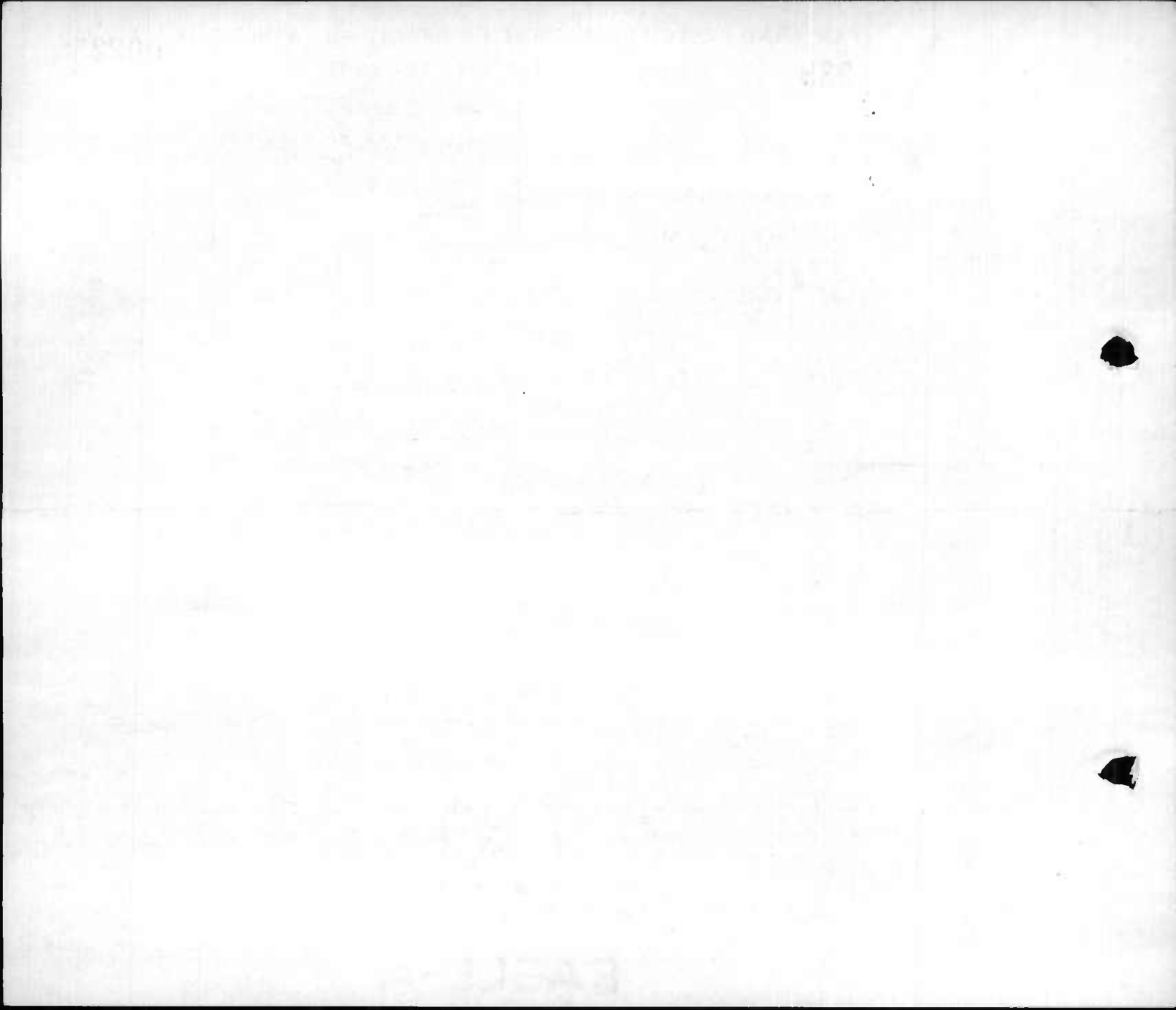


239

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>JONES CREEK</u>		<u>2 YRS</u>		TOWN <u>DUNDALK</u>		<u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>90 CARROLL MANOR HOME</u>				<u>34 PORTSHIP</u>			
3. NAME OF DECEASED:				4. DATE OF DEATH:			
(First) <u>ASA</u>		(Middle) <u>S.</u>		(Last) <u>COLLINS</u>		(Month) (Day) (Year)	
(Type or Print)						<u>JAN 15 1956</u>	
5. SEX:		5. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH:	
<u>MALE</u>		<u>WHITE</u>		<u>WIDOWED</u>		<u>JULY 5, 1867</u>	
						9. AGE last birthday: <u>88</u> yrs.	
						IF UNDER 1 YEAR IF UNDER 24 HRS.	
						Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): <u>HEATER</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>STEEL CO.</u>		11. BIRTHPLACE (State or foreign country): <u>OHIO</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>ASA S COLLINS</u>				14. MOTHER'S MAIDEN NAME: <u>SARAH DRUITT</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>MRS. ETHEL OBERLE 34 PORTSHIP</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>422.1 Arterio Sclerotic Cardio-Vascular Disease</u>							
Antecedent causes (s) (b) <u>Disease</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Senility</u>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
		INJURY					
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 1953</u> , to <u>Jan 15, 1956</u> , that I last saw the deceased alive on <u>Jan 15, 1956</u> , and that death occurred at <u>945 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Mrs. J. M. S.</u>				DATE SIGNED <u>Jan 16, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>JAN 18, 1956</u>		<u>BALTIMORE</u>		<u>BALTIMORE MD</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-56</u>		<u>[Signature]</u>		<u>WILLIAM FUNERAL HOME</u>		<u>4210 BELAIR</u>	





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## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>PIKESVILLE</u>		<u>45 yrs.</u>		TOWN <u>PIKESVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Waldron</u>				STREET ADDRESS (If rural give location) <u>7 WALDRON AVE.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH:			
(First) <u>Lydia</u> (Middle) <u>Brading</u> (Last) <u>COLWILL</u>				(Month) <u>JAN</u> (Day) <u>20</u> (Year) <u>1958</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>married</u>	<u>5-28-1870</u>	<u>85</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>HOUSEWIFE</u>				<u>HOME</u>		<u>London, England</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME:			
<u>U.S.A.</u>				<u>John Milton</u>			
14. MOTHER'S MAIDEN NAME:				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			
<u>Elizabeth Brown</u>				<u>no</u>			
16. SOCIAL SECURITY NO.				17. INFORMANT & ADDRESS:			
<u>NONE</u>				<u>Edward P. Colwill, Owings Mills, Md.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>arteriosclerotic heart disease</u>							<u>2 yrs.</u>
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>17 Jan., 1958</u> to <u>20 Jan., 1958</u> that I last saw the deceased alive on <u>17 Jan., 1958</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Paul H. Royce</u>				ADDRESS <u>Pikesville 8 md</u>		DATE SIGNED <u>20 Jan 58</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 23-58</u>		<u>David Neelys</u>		<u>Pikesville 8. md</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 21, 1958</u>		<u>Northy A. Newell</u>		<u>Frank H. Newell</u>		<u>Pikesville, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 1

JAN 27 1956

RECEIVED

241

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Baltimore		MARYLAND		STATE Maryland		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN Sparrows Point		25 Years		TOWN Sparrows Point		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
Box 314 Route 10, Penwood Ave.				Box 314, Route 10, Penwood Ave.			
3. NAME OF DECEASED:		(First) (Middle) (Last)		4. DATE OF DEATH:		(Month) (Day) (Year)	
(Type or Print)		CARL TRUMAN COOPER		Jan. 30,		19 56	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR IF UNDER 24 HRS.		
Male	White	Married	Feb. 2, 1905	50	Yrs.	Months	Days
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired.				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Analyst				Bethlehem Steel Co.		Kansas	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
Oliver W. Cooper				Esther Hampe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
No.		213-07-9418		Mrs. Maisie Cooper, Box 314 Penwood Ave-19			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				Interval Between Onset And Death			
420.1 Immediate cause (a) DUE TO				Coronary Occlusion			
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO				Coronary Arteriosclerosis			
(c)				I insufficiency			
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY?				Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 24, 1956, to Jan. 30, 1956, that I last saw the deceased alive on Jan. 27, 1956, and that death occurred at 12:45 PM, from the causes and on the date stated above.							
SIGNATURE		(Degree or title)		ADDRESS		DATE SIGNED	
David Owens, M.D.				914 D Street Balto. 19.		1/31/56	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		Feb. 2, 1956		Lorraine		Woddlam, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
Jan. 31-56		Dawson L. Harbor		Ullrich Funeral Home		2112 Dundalk Ave.	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. B.

FEB 3 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A19C 1-55 10M

198

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00228

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 8, Film G191 1-26-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO</u>		MARYLAND		STATE <u>PA</u>		COUNTY <u>DAKE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>53 DUNDALK (22)</u>		LENGTH OF STAY (in this place) <u>5 YRS</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>#1</u>		TOWN <u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>8221 BULLNECK RD.</u>				STREET ADDRESS (If rural give location) <u>53</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>CURIE PFLAUM CULHANE</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 15, 1956</u>			
5. SEX <u>FEM.</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOW</u>	8. DATE OF BIRTH <u>NOV. 18, 1893</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>PENNA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ANDREW PFLAUM</u>				14. MOTHER'S MAIDEN NAME <u>TILLIE MOHR</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>MRS. WM. M. SMALL - SAME</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>420.0 IMMEDIATE CAUSE (A) arterio sclerotic heart disease</u>						3 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Hypertension Cardiovascular disease</u>							
(C) <u>Rheumatic arthritis</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>53</u> , to <u>1-15</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-15</u> , 19 <u>56</u> , and that death occurred at <u>4 P.</u> , M., from the causes and on the date stated above.							
SIGNATURE <u>Eugene F Nevy</u>				DATE SIGNED <u>M.D. 7001 Mornington Rd Dundalk, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-14-56</u>		NAME OF CEMETERY OR CREMATORY <u>TRINITY</u>		LOCATION (City, town, or county) (State) <u>ERIE, PENNA.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>William M. Kelly</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur Bradley</u>		ADDRESS <u>Dundalk, Md.</u>	
DATE <u>Jan. 6 - 1956</u>							

THIS IS A PRELIMINARY REPORT OF THE RESULTS OF THE INVESTIGATION OF THE CASE OF THE DEATH OF THE PERSON NAMED ABOVE. THE RESULTS OF THE INVESTIGATION OF THE CASE OF THE DEATH OF THE PERSON NAMED ABOVE ARE AS FOLLOWS: THE PERSON NAMED ABOVE WAS FOUND DEAD ON THE DAY OF THE DEATH OF THE PERSON NAMED ABOVE. THE RESULTS OF THE INVESTIGATION OF THE CASE OF THE DEATH OF THE PERSON NAMED ABOVE ARE AS FOLLOWS: THE PERSON NAMED ABOVE WAS FOUND DEAD ON THE DAY OF THE DEATH OF THE PERSON NAMED ABOVE.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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BUREAU V. S.

JAN 18 1956

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

242

00229

Reg. Dist.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 33

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Boring</u>		LENGTH OF STAY (In this place) <u>20 yrs.</u>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Boring</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural, give location)		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Florence L. Cullison</u>			4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 10 19 56</u>		
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>July 7, 1881</u>	9. AGE last birthday: <u>74</u> yrs.	IF UNDER 1 YEAR Months Days Hours Mln.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>own home</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Kinsey B. Myers</u>			14. MOTHER'S MAIDEN NAME: <u>Mary C. Rawlings</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>212-34-1436B</u>		17. INFORMANT & ADDRESS: <u>Edgar P. Cullison, Boring, Md.</u>	
18. MEDICAL CERTIFICATION					
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:					INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Coronary Occlusion</u>					<u>5 min.</u>
DUE TO					
Antecedent cause(s) (b) <u>Angina Pectoris</u>					<u>3 years</u>
Diseases or conditions, if any, giving rise to the above cause DUE TO					
stating underlying cause last (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:			20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
<u>none</u>		<u>none</u>			(State)
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <u>none</u>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <u>none</u>		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR? <u>none</u>	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>D. D. Caples</u>		CHIEF MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER M. D. ASSISTANT MEDICAL EXAM.		DATE SIGNED <u>Jan. 11, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan. 14, 1956</u>		LOCATION (City, town, or county) (State) <u>Mt. Zion Balto. Co., Maryland</u>	
DATE REC'D BY LOCAL REG. <u>1-12-56</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR ADDRESS <u>Edw. C. Tipton, Hampstead, Md.</u>	

RECEIVED

JAN 19 1956

BUREAU V. S.

243

CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Cockeysville</u>		LENGTH OF STAY (in this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd.</u>				STREET ADDRESS (If rural give location) <u>York Rd.</u>			
3. NAME OF DECEASED: (First) <u>Grace</u> (Middle) <u>Bryant</u> (Last) <u>Cunsey</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 12</u> <u>1956</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>May 22, 1907</u>	
				9. AGE last birthday <u>48</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>retail clothing</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Herbert R. Stevenson</u>				14. MOTHER'S MAIDEN NAME: <u>Lida Perbs</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>2155-24-1517</u>		17. INFORMANT & ADDRESS: <u>Mrs. Herbert Stevenson, Cockeysville, Md.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Respiratory failure</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Metastatic carcinoma gen'l.</u>						<u>1 1/2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma Right breast</u>						<u>8 yrs.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>1948</u>				19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY atreet, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Feb.</u> , 19 <u>54</u> to <u>Jan. 12</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 11</u> , 19 <u>56</u> and that death occurred at <u>5:40 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Elizabeth B. Sherrill</u>				ADDRESS <u>Cockeysville, Md.</u>		DATE SIGNED <u>1/12/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Buried</u>		DATE THEREOF <u>1-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>Bosley Methodist</u>		LOCATION (City, town, or county) (State) <u>Sparks, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>12 January 1956</u>		REGISTRAR'S SIGNATURE <u>Ann Armistead MacRae</u>		24. FUNERAL DIRECTOR <u>L. Scott Bechtel</u>		ADDRESS <u>Sparks, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 16 1956

RECEIVED

1

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

244

# CERTIFICATE OF DEATH

00231

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Catonville</u>				TOWN <u>Catonville</u>		52	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Home</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>Algie E. Davis</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>1-20 1956</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>W</u>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>W</u>		<b>8. DATE OF BIRTH</b> <u>4-9-92</u>	
				<b>9. AGE last birthday</b> <u>63</u> yrs.		<b>IF UNDER 1 YEAR</b> (Months) (Days) (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Calc.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Beth Steel</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maine</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>William</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary E. Towle</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Family - Same</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>155X</b> IMMEDIATE CAUSE (A) <u>Carcinomatosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma liver (primary)</u>				DUE TO (C) <u>Arteriosclerosis, generalized</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>1955</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Carcinomatosis - abdominal cavity</u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M. A. P. M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from 1-20, 1956, to 1-20, 1956, that I last saw the deceased alive on 1-20, 1956, and that death occurred at 10:30 A.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Stephen L. Hapness</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Catonville 28 Rd 1-20-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>B</u>		<b>DATE THEREOF</b> <u>1-23-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Good Hope</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Balto</u>	
<b>24. REC'D BY REGISTRAR</b> <u>JAN 23 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>V. E. Harris</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>W. A. Carey</u>		<b>ADDRESS</b> <u>Funeral Home</u>	





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00232  
245 CERTIFICATE OF DEATH Reg. Dist. No. 30

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>5743 Edmondson Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Catonsville</u> STREET ADDRESS (If rural give location) <u>5743 Edmondson Ave.</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) <u>GRACE M. DAVIS</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 4, 1956</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>June 1, 1889</u>
9. AGE last birthday <u>66</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Homemaker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>at home</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Wm. T. Davis</u>		14. MOTHER'S MAIDEN NAME: <u>Sarah Haines</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT & ADDRESS: <u>Linthicum, Md.</u> <u>Mr. Joseph S. Davis, Sr. 418 Forest View Rd</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Cerebral vascular Accident</u>			<u>18 hrs.</u>
ANTECEDENT CAUSE (B) <u>Hypertensive Cardiovascular Dis.</u>			<u>2 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec 27, 1953</u> to <u>Jan 4, 1956</u> , that I last saw the deceased alive on <u>Jan 3, 1956</u> , and that death occurred at <u>4:30 P. M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>J. McKee McKee</u>		ADDRESS <u>M. D. 6014 Edmondson Ave.</u>	
DATE SIGNED <u>1/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/6/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 5, 1956</u>		REGISTRAR'S SIGNATURE <u>Carroll H. H. H.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Dickner &amp; Sons - Balto</u>		ADDRESS <u>17 Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1440

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Maryland</i> COUNTY <i>Baltimore</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>MT Wilson</i>	LENGTH OF STAY (In this place) <i>2 days</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Baltimore</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>MT Wilson State Hospital</i>		STREET ADDRESS (If rural, give location) <i>Old Washington Blvd. and Sterwood Road</i>	
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(Type or Print) <i>Raymond</i>	(First) (Middle) (Last) <i>Davis</i>	<i>1 - 28 - 1956</i>	
5. SEX: <i>male</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>single</i>	8. DATE OF BIRTH: <i>2 - 2 - 1904</i>
9. AGE last birthday <i>51</i> yrs.		10. AGE last birthday	
11. BIRTHPLACE (State or foreign country): <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>George Thomas Davis</i>		14. MOTHER'S MAIDEN NAME: <i>Carrie Kinney</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>no</i>		16. SOCIAL SECURITY NO. <i>2</i>	
17. INFORMANT'S ADDRESS: <i>Maynard Davis, Box 213 B Elkridge Md</i>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (A) <i>Pulmonary Tuberculosis</i>			<i>?</i>
ANTECEDENT CAUSE (S): DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1-27-</i> , 1956, to <i>1-28-</i> , 1956, that I last saw the deceased alive on <i>1-28-</i> , 1956, and that death occurred at <i>2 P. M.</i> , from the causes and on the date stated above.			
SIGNATURE <i>William Newman</i>		DATE SIGNED <i>1-28-56</i>	
23. BURIAL, CREMATION, REMOVAL OF REMAINS		NAME OF CEMETERY OR CREMATORY	
DATE THEREOF <i>1/31/56</i>		LOCATION (City, town, or county) (State) <i>Baltimore, Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>FEB 15</i>		REGISTRAR'S SIGNATURE <i>Dorothy Newell</i>	
24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 16 1956

BUREAU V. S.

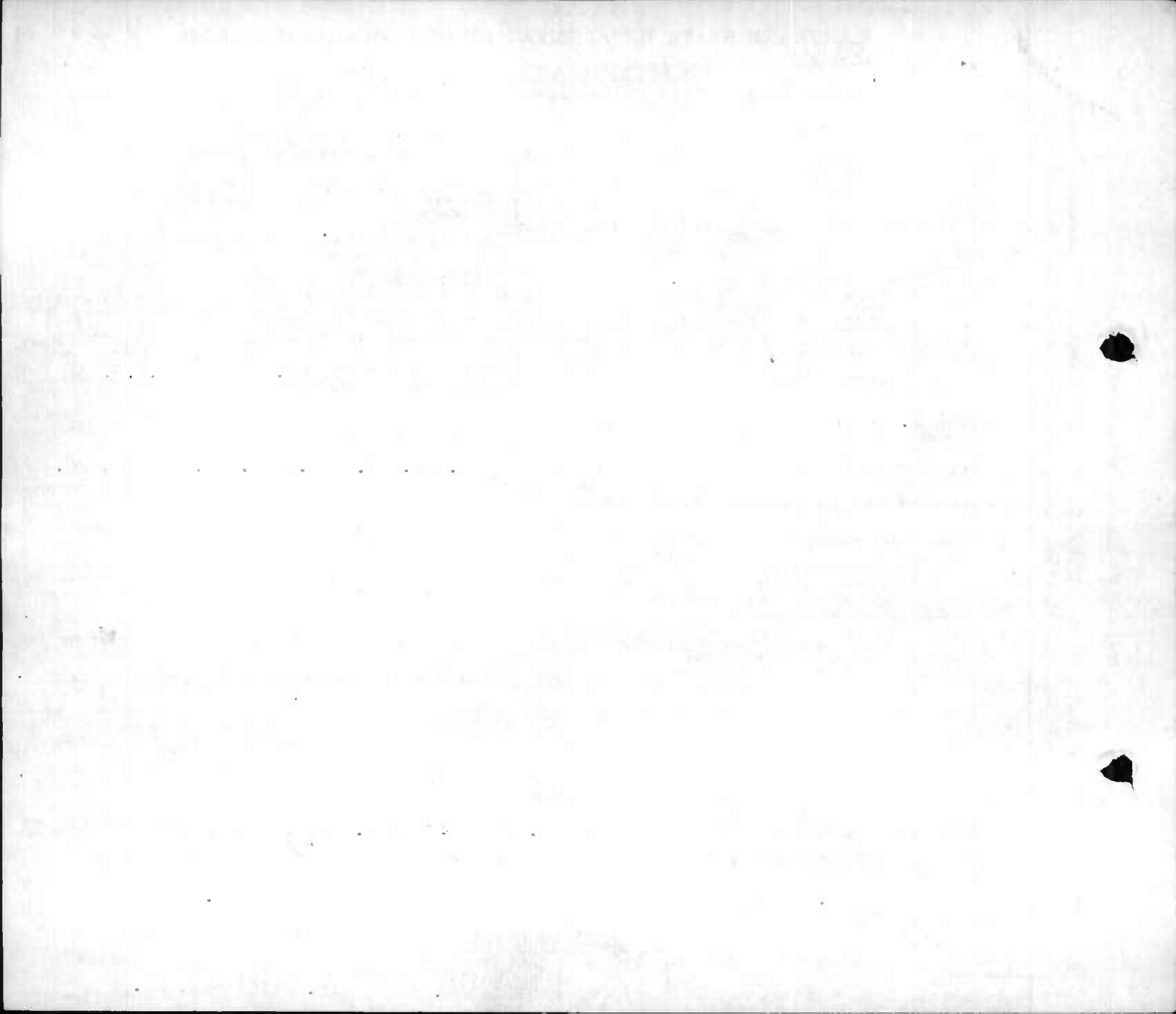
CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town) <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>28 Days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>3111 N. Charles Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES F. DEANE (ALSO: DEAN)</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>January 28 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>11/12/73</u>	9. AGE last birthday <u>82</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Salesman</u>			10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>East New Market, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Frank H. Deane</u>				14. MOTHER'S MAIDEN NAME: <u>Emma Vane</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>OW</u>			16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>		
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>MASSIVE GASTROINTESTINAL HEMORRHAGE</u>						<u>UNKNOWN</u>	
ANTECEDENT CAUSE (S) <u>MULTIPLE GASTRIC ULCERATIONS</u>						<u>UNKNOWN</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>DIABETES MELLITUS</u>						<u>1 YEAR</u>	
<u>BENIGN PROSTATIC HYPERTROPHY</u>						<u>1 YEAR</u>	
19A. DATE OF OPERATION: <u>1/23/56</u>		19B. MAJOR FINDINGS OF OPERATION <u>SUPRAPUBIC PROSTATOCYSTOTOMY</u>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>VA</u> M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Dec. 31, 1955, to Jan. 28, 1956, that I last saw the deceased <u>alive on</u> and that death occurred at <u>6:50 PM</u> , from the causes and on the date stated above. SIGNATURE <u>DONALD D. MARK</u> M. D. <u>VAH, Fort Howard, Md.</u> DATE SIGNED							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 31/56</u>		NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-31-56</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedridge</u>		24. FUNERAL DIRECTOR <u>Stewart &amp; Mowen Funeral Home</u>		ADDRESS <u>108 W. North Ave. Baltimore, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

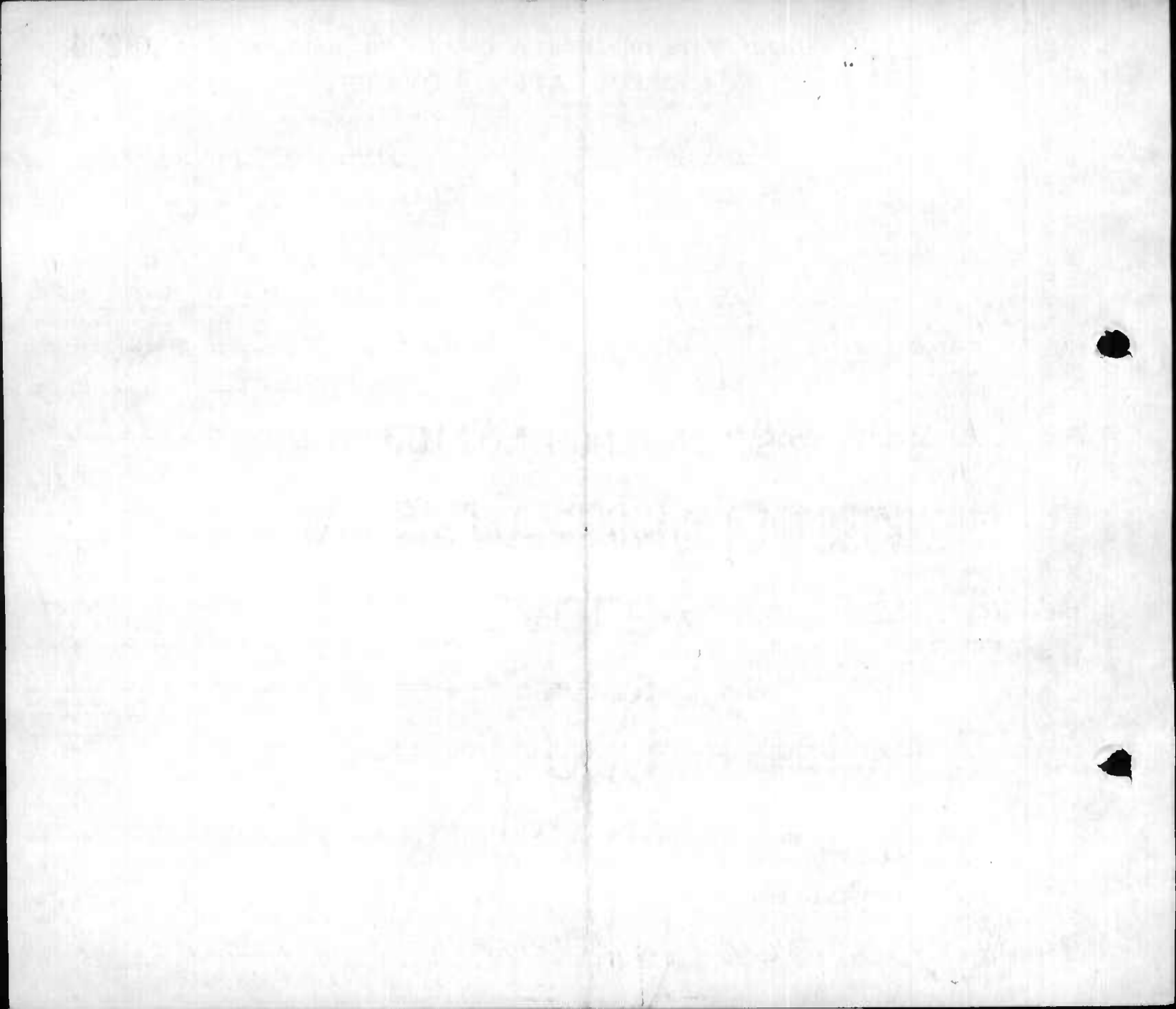
247

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00234

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
TOWN <u>Overlea</u>		<u>35 yrs.</u>		TOWN <u>Overlea</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7 Madeline Ave</u>				STREET ADDRESS (If rural give location) <u>7 Madeline Ave</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Barbara M. Decker</u>				<u>Jan 15 1956</u>			
5. SEX: <u>F.</u>		6. COLOR OR RACE: <u>W.</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>Sept 15 1879</u>	
				9. AGE last birthday <u>76</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>At Home</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Housework</u>		11. BIRTHPLACE (State or foreign country): <u>Balto. Co.</u>	
13. FATHER'S NAME: <u>Andrew Redel</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Raab</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY No. <u>215-09-0499</u>		17. INFORMANT & ADDRESS: <u>Margaret M. Sherman 7 Madeline Ave</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0 Hypertensive - Arteriosclerotic Heart Disease</u>						<u>10 yr.</u>	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
		M.					
22. I hereby certify that I attended the deceased from <u>Dec. 11, 1947</u> , to <u>Jan. 15, 1956</u> that I last saw the deceased alive on <u>Jan. 11, 1956</u> , and that death occurred at <u>1:05</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Adam G. Lewis</u>				ADDRESS <u>6222 Belair Road</u>		DATE SIGNED <u>Jan. 16, 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN 18, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>HOLY REDEEMER</u>		LOCATION (City, town or county) (State) <u>BELAIR RD MD</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-18-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Duffel Bros</u>		ADDRESS <u>7110 BELAIR RD</u>	



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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00235

CERTIFICATE OF DEATH

Reg. Dist. No. 36

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Towson</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>105 Ware Avenue</b>				STREET ADDRESS (If rural give location) <b>105 Ware Avenue</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>AUGUST C. DEICHELMAUN</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>January 2, 1956</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Widower</b>	8. DATE OF BIRTH: <b>December 3, 1872</b>	9. AGE last birthday <b>83</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Self employed</b>		11. BIRTHPLACE (State or foreign country): <b>Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Arnold Detchelmann</b>				14. MOTHER'S MAIDEN NAME: <b>Rosina Messler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS: <b>Mrs. Thomas Hawkins, Balto., Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						3 YRS.	
IMMEDIATE CAUSE (A) <b>CARCINOMA OF PROSTATE</b>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Dec. 31, 1955</b> , to <b>Jan. 2, 1956</b> , that I last saw the deceased alive on <b>Dec. 31, 1955</b> , and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above.							
SIGNATURE <b>William G. Trisberg</b>		M. D. <b>Trisberg</b>		ADDRESS <b>Towson, Maryland</b>		DATE SIGNED <b>1/5/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jan. 6, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Holy Redeemer Cemetery</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>Jan. 5, 1956</b>		REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>		4. FUNERAL DIRECTOR <b>John Burns Son</b>		ADDRESS <b>Towson, Maryland</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 6 1956

BUREAU, W. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

205

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00236

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Item 13 Film G192 2-21-56 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1805 Selma Ave.</u>		STREET ADDRESS (If rural give location) <u>1805 Selma Ave.</u>	
3. NAME OF DECEASED (First) <u>GERALD</u> (Middle) <u>MICHAEL</u> (Last) <u>DELIHANT</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>31</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Oct 31 1935</u>	
9. AGE last birthday <u>80</u> yrs.		10. If under 1 year Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Paper manufacturing</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.O.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Thomas Delihant</u>		14. MOTHER'S MAIDEN NAME <u>Fitzgould</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>215-09-0992</u>	
(If yes, give war or dates of service) <u>No</u>		17. INFORMANT <u>Lillian Delihant (wife)</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
422.1 Immediate cause (a) <u>Acute Colitis &amp; Cystitis</u>		3da	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Chronic Myocarditis</u>		1 yr	
(c) <u>Generalized arteriosclerosis</u>		5 1/2 yrs	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Cerebral embolus</u>		3 1/2 yrs	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT (Specify) <u>SUICIDE</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY</u>	
(CITY OR TOWN) <u>Baltimore</u> (COUNTY) <u>Baltimore</u> (STATE) <u>Md.</u>			
TIME (Month) (Day) (Year) (Hour) <u>5:33</u> OF INJURY <u>While at Work</u>		INJURY OCCURRED <u>Not While At work</u>	
HOW DID INJURY OCCUR? <u>Shot</u>			

22. I hereby certify that I attended the deceased from Jan 21, 1956, to Jan 31, 1956, that I last saw the deceased alive on Jan 31, 1956, and that death occurred at 5:33 m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb 3 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Greenwood</u>		LOCATION (City, town, or county) <u>Frederick, Md.</u>	
DATE REC'D BY LOCAL REG. <u>Feb 2 1956</u>		REGISTRAR'S SIGNATURE <u>For Keiffer</u>		24. FUNERAL DIRECTOR <u>Seville/Gray</u>		ADDRESS <u>1646 Carroll Ave.</u>	

BUREAU V. 3

FEB 6 1956

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

249

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00237

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Balto. Co.</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<b>Sorenson Nursing Home 7912 Ruxway Rd.</b>		STREET ADDRESS (If rural give location) <b>711 Morningside Drive</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<b>LOUISA G. DEPKIN</b>				<b>Jan. 15, 19 56</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Female</b>	<b>White</b>	<b>widowed</b>	<b>July 4, 1863</b>	<b>92 yrs.</b>	<b>6 Months</b>	<b>10 Days</b>	<b>Hours Min.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Housewife</b>		<b>at Home</b>		<b>Md.</b>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Herman Gohlinghorst</b>				<b>Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<b>no</b>				<b>Drive, Towson, Md. Mrs. Dorothea G. White-711 Morningside</b>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <b>Myocarditis chronic with failure</b>						<b>acute</b> <b>5 yrs</b>	
ANTECEDENT CAUSE (S) DUE TO (B) <b>Hypertrophy myocardium</b>						<b>7 days</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Congestion of lungs</b>						<b>5 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Advanced age.</b>						<b>7 days</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<b>none</b>		<b>no operation</b>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
		<b>none</b>		<b>no injury</b>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<b>none</b>		<b>none</b>		<b>none</b>			
22. I hereby certify that I attended the deceased from <b>Nov 6-</b> , 19 <b>55</b> , to <b>1-15-</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1-14-</b> , 19 <b>56</b> , and that death occurred at <b>12.40M</b> , from the causes and on the date stated above.							
SIGNATURE <b>Garnes Graham Manton.</b>				M. D. <b>516 Cathedral St. Balto Md 17</b>		DATE SIGNED <b>Jan 1956</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1/18/56</b>		<b>Loudon Park Cem.</b>		<b>Balto., Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>1-18-56</b>		<b>Dr. Reduct</b>		<b>Chas. J. Lickner</b>		<b>Balto 17 Md.</b>	

THE UNIVERSITY OF CHICAGO  
DEPARTMENT OF CHEMISTRY  
CHICAGO, ILLINOIS  
JANUARY 1950

TO THE DIRECTOR OF THE NATIONAL BUREAU OF STANDARDS  
WASHINGTON, D. C.

FROM THE DIRECTOR OF THE UNIVERSITY OF CHICAGO  
DEPARTMENT OF CHEMISTRY

SUBJECT: [Illegible]

[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a formal letter or report.]

VALLEY

250

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

8379

MARGIN RESERVED FOR BINDING

VS. A15-10-53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Md.
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Catonville	COUNTY	Prince George's
TOWN	Spring Grove	CITY (If outside corporate limits, write RURAL OR and give nearest town)	Washington (Pine Grove)
HOSPITAL OR INSTITUTION OR STREET ADDRESS	State Hosp	STREET ADDRESS (If rural give location)	668 Walkermill Rd.
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
Bessie May Dickey		1 10 1956	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
F	W	Widowed	9-20-1887
9. AGE last birthday		10. IF UNDER 1 YEAR Months Days	
67 yrs.		11. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life)		10B. KIND OF BUSINESS OR INDUSTRY:	
Book keeper own Feed business		11. BIRTHPLACE (State or foreign country):	
Washington, D.C.		12. CITIZEN OF WHAT COUNTRY?	
U.S.A.		13. FATHER'S NAME:	
Roy Houck		14. MOTHER'S MAIDEN NAME:	
Emma Lamb		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
No		16. SOCIAL SECURITY NO.	
Unknown		17. INFORMANT & ADDRESS:	
Records Spring Grove State Hosp		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
422.1			
IMMEDIATE CAUSE		(A) DUE TO	
Congestive heart failure		(B) DUE TO	
Anteriosclerotic Cardiovascular disease		(C) DUE TO	
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		Chronic Brain Syndrome assoc. w/ cerebral arteriosclerosis	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 1/4/1956 to 1/10/1956, that I last saw the deceased alive on 1/10/1956, and that death occurred at 7:30 P.M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Stella Wachler		1/11/56	
M. D. Catonsville			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		1/13/56	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Cedar Hill Cemetery		Suitland Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
1/18/56		V E. Harry	
24. FUNERAL DIRECTOR		ADDRESS	
F. Pasche Sons		Hyattsville Md	

BUREAU V. 2

JAN 19 1956

RECEIVED

251

## CERTIFICATE OF DEATH

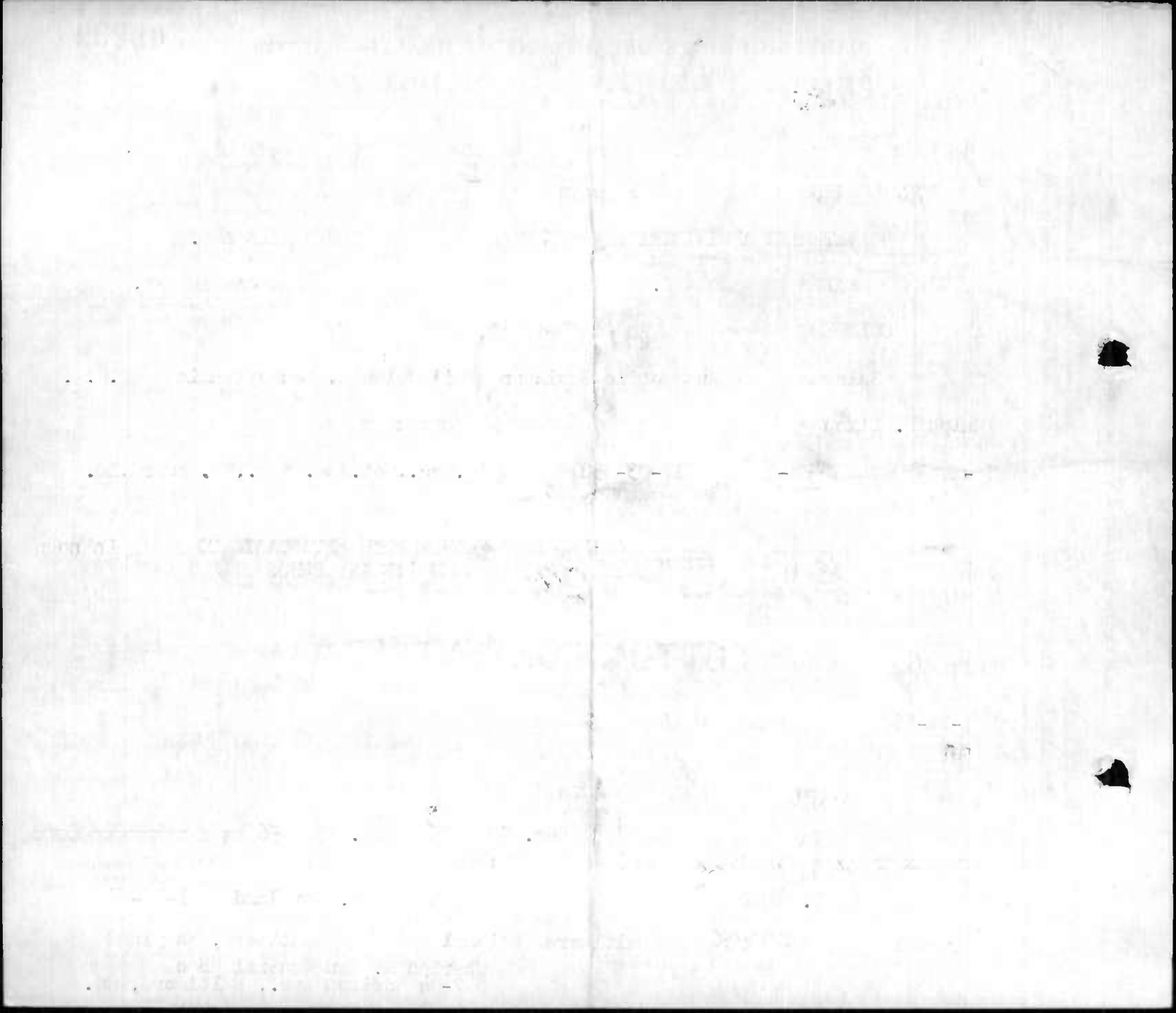
Reg. Dist. No. *XX*

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>16 Days</b>		TOWN <b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1610 DRUID HILL AVENUE</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>RALPH F. DIXON</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>JANUARY 15, 1956</b>			
5. SEX: <b>MALE</b>		6. COLOR OR RACE: <b>COLORED</b>		7. SINGLE. MARRIED. WIDOWED, DIVORCED. (Specify) <b>MARRIED</b>		8. DATE OF BIRTH: <b>April 19, 1898</b>	
				9. AGE last birthday <b>57</b> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Salesman</b>				10B. KIND OF BUSINESS OR INDUSTRY: <b>Automobile Business</b>		11. BIRTHPLACE (State or foreign country): <b>Philadelphia, Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME: <b>Ralph F. Dixon</b>				14. MOTHER'S MAIDEN NAME: <b>Bertha Brown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service) <b>Yes</b> <b>WW-1</b>				16. SOCIAL SECURITY NO. <b>217-03-2320</b>		17. INFORMANT & ADDRESS: <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>CARCINOMA OF PROSTATE WITH METASTASIS TO RECTUM, SEMINAL VESICULE AND LUNGS</b>						Unknown	
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <b>1-12-56</b>		19B. MAJOR FINDINGS OF OPERATION: <b>TRANSRECTAL BIOPSY</b>				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify, that I attended the deceased from <b>Dec. 30, 1955, to Jan. 15, 1956</b> , and that death occurred at <b>10:15 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>D. D. MARK</b>				ADDRESS <b>M. D. Fort Howard, Maryland</b>		DATE SIGNED <b>1-15-56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/19/56</b>		NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1-16-56</b>		REGISTRAR'S SIGNATURE <b>John Dedrick</b>		ADDRESS <b>Charles R. Law Funeral Home 802-04 Madison Ave., Baltimore, Md.</b>			

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

252

## CERTIFICATE OF DEATH

00240

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		LENGTH OF STAY (in this place) <b>14 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		TOWN <b>BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>2018 SWANSEA ROAD</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>CHARLES R. DONNELLY</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>JANUARY 16 1956</b>			
<b>5. SEX</b> <b>MALE</b>		<b>6. COLOR OR RACE</b> <b>WHITE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <b>MARRIED</b>		<b>8. DATE OF BIRTH</b> <b>September 8, 1888</b>	
<b>9. AGE last birthday</b> <b>67</b> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Fireman</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>City</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>New York, N. Y.</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>		<b>13. FATHER'S NAME</b> <b>James Donnelly</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mary MN: Holmes</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>219-05-1863</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>465X</b> IMMEDIATE CAUSE (A) <b>PULMONARY EMBOLUS</b>						INTERVAL BETWEEN ONSET AND DEATH <b>12 HOURS</b>	
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>1. Benign prostatic hypertrophy</b>						<b>4 Months</b>	
<b>2. Pulmonary emphysema</b>						<b>7 Years</b>	
<b>3. Bronchiectasis</b>							
<b>19a. DATE OF OPERATION</b> <b>1/10/56</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <b>Transurethral resection</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that</b> <b>VA</b> attended the deceased from <b>Jan. 2</b> , 19 <b>56</b> , to <b>Jan. 16</b> , 19 <b>56</b> , and that death occurred at <b>10:20 P.M.</b> from the causes and on the date stated above.							
<b>SIGNATURE</b> <b>M. D. Joseph M. Miller</b>		<b>ADDRESS</b> (Street, city, town, state) <b>VAH FORT HOWARD, MARYLAND</b>		<b>DATE SIGNED</b> <b>1-17-56</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>1-20-56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>New Cathedral Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Dawson L. Fisher</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc.</b>		<b>ADDRESS</b> <b>6009 Harford Rd., Balto. Md.</b>	
<b>DATE</b> <b>Jan. 20, 1956</b>							

# CERTIFICATE OF DEATH

238

Reg. Dist. No.

1. USE OF RESERVING NUMBER IN DECEASED

2. PLACE OF BIRTH

3. SEX AND

4. DATE OF BIRTH

5. AGE

6. USUAL PLACE OF RESIDENCE AT TIME

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SEX

11. TIME OF DEATH

12. DATE OF DEATH

13. PLACE OF DEATH

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF REGISTRAR

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF DECEASED

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83. SIGNATURE OF DECEASED

BUREAU V. S.

JAN 20 1956

RECEIVED

SMOULDERING

253

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Catonsville</u>		<u>33yrs. 3mth.</u>		<u>Baltimore City</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>Bayview Hospital - Bayview, Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Hannah</u> <u>Dubin</u>				<u>Jan. 26</u> <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>female</u>	<u>white</u>	<u>Single</u>	<u>unknown</u>	<u>73</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>none</u>				<u>Russia</u>		<u>unknown</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Moses Dubin</u>				<u>Jennie Yeffe</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
<u>unknown</u>		<u>unknown</u>		<u>Records of Spring Grove State Hosp.</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cardio-vascular accident</u>							
ANTECEDENT CAUSE (S) <u>Generalized arteriosclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Diabetes Mellitus</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 1953, to <u>Jan. 26</u> , 1956 that I last saw the deceased alive on <u>Jan. 26</u> , 1956, and that death occurred at <u>3:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Gulla Warshler</u>		ADDRESS <u>SPRING GROVE STATE HOSP.</u>		DATE SIGNED <u>Jan. 26, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Unburied</u>		DATE THEREOF <u>1/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>FEB 15 1956</u>		REGISTRAR'S SIGNATURE <u>T. E. Harvey</u>		24. FUNERAL DIRECTOR		ADDRESS	

146

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BUREAU V. S.

FEB 16 1956

RECEIVED

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00241

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>		COUNTY <u>P</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>CATONSVILLE</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>2692 ST. BENEDICT ST.</u>		TOWN <u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Ridgway Manor Nursing Home</u>				STREET ADDRESS (If rural give location)			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Joseph Richard Edler</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Jan. 16, 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widowed</u>		8. DATE OF BIRTH <u>Aug 4 1892</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LAY OUT MAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MILLWORK</u>		9. AGE last birthday <u>63</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>Joseph Edler</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>				16. SOCIAL SECURITY NO. <u>216-01-8733A</u>		17. INFORMANT & ADDRESS <u>Joseph H. Edler 3140 WILKENS AVE.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>420.1 Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio Vascular Disease</u>				?			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from Jan 8, 1956, to Jan 16, 1956, that I last saw the deceased alive on Jan 16, 1956, and that death occurred at 7:15 P.M. from the causes and on the date stated above. Jan 17, 1956</b>							
SIGNATURE <u>Henry Glassman</u> M.D.				ADDRESS (Street, city, town, state) <u>2687 Madison Ave Baltimore</u> DATE SIGNED <u>Jan 17, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-20-56</u>		NAME OF CEMETERY OR CREMATORY <u>LONDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
24. REC'D BY REGISTRAR <u>Jan 18, 1956</u>		REGISTRAR'S SIGNATURE <u>V.E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George R. Schwab</u>		ADDRESS <u>2101 Frederick Ave</u>	





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00242

255

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>M Essex - 24</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7308 Kirtley Rd.</u>				STREET ADDRESS (If rural give location) <u>7308 Kirtley Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ANNA</u> (First) <u>ELGERT</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>Jan.</u> (Day) <u>9</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>married</u>	<b>8. DATE OF BIRTH</b> <u>Nov. 6. 1913</u>	<b>9. AGE last birthday</b> <u>42</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>- - -</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Henry Bauers</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Maggie Biggerman</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S ADDRESS</b> <u>Mr. Arthur R. Elgert (Husband)</u> <u>7308 Kirtley Rd. - 24</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE (A)</b> <u>Acute and chronic myocardial insufficiency</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>45 days</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Metastatic lesions of the lower lumbar spine, pelvis</u>				<u>1 year</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> <u>upper one third of both femurs, right optic nerve</u>				<u>5 years</u>			
<b>(C)</b> <u>Medullary, scirrhous carcinoma, left breast</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>12 Dec 50</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>see (c) above</u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) <u>M.</u>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21i. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>27 Sept</u>, 19<u>47</u>, to <u>9 Jan</u>, 19<u>56</u>, that I last saw the deceased alive on <u>9 Jan</u>, 19<u>56</u>, and that death occurred at <u>7:45 A</u>.M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>D. B. Bronush, M.D.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>2037 O'Donnell St Baltimore Md.</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Jan. 13. 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Oak Lawn Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Baltimore County Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>JAN 10 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. Edith Hurley</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HENRY SANDER &amp; SONS, INC.</u> <u>Baltimore Md.</u>			

1955

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

# CERTIFICATE OF DEATH

DATE OF DEATH

1. NAME OF DECEASED

2. SEX

3. AGE

4. RACE

5. BIRTH DATE

6. BIRTH PLACE

7. MARRIAGE DATE

8. MARRIAGE PLACE

9. OCCUPATION

10. CAUSE OF DEATH

11. PLACE OF DEATH

12. TIME OF DEATH

13. SIGNATURE OF DECEASED

14. SIGNATURE OF WITNESS

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF CORONER

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF NOTARY

20. SIGNATURE OF OTHER

21. SIGNATURE OF DECEASED

22. SIGNATURE OF WITNESS

23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF CORONER

25. SIGNATURE OF JUDGE

26. SIGNATURE OF CLERK

27. SIGNATURE OF NOTARY

28. SIGNATURE OF OTHER

29. SIGNATURE OF DECEASED

30. SIGNATURE OF WITNESS

31. SIGNATURE OF PHYSICIAN

32. SIGNATURE OF CORONER

33. SIGNATURE OF JUDGE

34. SIGNATURE OF CLERK

35. SIGNATURE OF NOTARY

36. SIGNATURE OF OTHER

37. SIGNATURE OF DECEASED

38. SIGNATURE OF WITNESS

39. SIGNATURE OF PHYSICIAN

40. SIGNATURE OF CORONER

41. SIGNATURE OF JUDGE

42. SIGNATURE OF CLERK

43. SIGNATURE OF NOTARY

44. SIGNATURE OF OTHER

45. SIGNATURE OF DECEASED

46. SIGNATURE OF WITNESS

47. SIGNATURE OF PHYSICIAN

48. SIGNATURE OF CORONER

49. SIGNATURE OF JUDGE

50. SIGNATURE OF CLERK

51. SIGNATURE OF NOTARY

52. SIGNATURE OF OTHER

BUREAU V. S.

JAN 10 1956

RECEIVED

2007 JAN 10 1956

THIS CERTIFICATE OF DEATH IS A PUBLIC DOCUMENT AND IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE CLERK OF THE COURT. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH. IT IS NOT TO BE USED FOR ANY OTHER PURPOSE. IT IS THE PROPERTY OF THE STATE DEPARTMENT OF HEALTH AND IS TO BE KEPT IN THE OFFICE OF THE CLERK OF THE COURT. IT IS NOT TO BE REPRODUCED OR COPIED IN ANY MANNER WITHOUT THE WRITTEN PERMISSION OF THE STATE DEPARTMENT OF HEALTH.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

255

## CERTIFICATE OF DEATH

00243

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Oella</u>		<u>15 yrs</u>		TOWN <u>Oella</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rock Springs, Ellicott City</u>				STREET ADDRESS (If rural give location) <u>Rock Springs, Ellicott City</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Lee Ellis</u>				<u>Jan. 6 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>Dec. 25, 1879</u>	<u>76</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>Retired Electrician,</u>					<u>Balto. Md.</u>		<u>U.S.A</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Ellis</u>				<u>Mary Sherwood</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<u>Mrs. Rose Ellis, Rock Springs,</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>420.1</u> IMMEDIATE CAUSE (A)				<u>Ellicott City, Md.</u>		<u>10 min.</u>	
ANTECEDENT CAUSE(S) DUE TO				<u>Coronary Thrombosis</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Arteriosclerotic Cardio Vascular Disease</u>		<u>2 yr.</u>	
STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>			
<u>none</u>		<u>none</u>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>4/22</u>, 19<u>55</u>, to <u>1/6</u>, 19<u>56</u>, that I last saw the deceased alive on <u>1/6</u>, 19<u>56</u>, and that death occurred at <u>11</u> PM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<u>George E. Burgtorf</u> M.D.				<u>Church St. ELlicott City, Md.</u>		<u>1/6/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify)</b>		<b>DATE WHEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial</u>		<u>Jan. 9/56</u>		<u>Woodlawn</u>		<u>Woodlawn 7, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<u>Jan. 9, 1956</u>		<u>V.E. Harry</u>		<u>Harry H. Witzke</u>		<u>4101 E dmondson Ave</u>	

THIS CERTIFICATE IS TO BE FILLED OUT BY THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH. IT IS TO BE SIGNED AND DATED BY HIM, AND TO BE FILED IN THE OFFICE OF THE HEALTH DEPARTMENT, BALTIMORE, MARYLAND, WITHIN TEN DAYS OF THE DEATH. IT IS TO BE RETURNED TO THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH, WHO IS TO BE RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED. IT IS TO BE FURNISHED TO THE PHYSICIAN OR OTHER PERSON QUALIFIED TO JUDGE OF THE CAUSE OF DEATH, WHO IS TO BE RESPONSIBLE FOR THE ACCURACY OF THE INFORMATION FURNISHED.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 12

1. DEATH OF DEATH

2. DEATH OF DEATH		3. DEATH OF DEATH		4. DEATH OF DEATH	
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89. DEATH OF DEATH		90. DEATH OF DEATH		91. DEATH OF DEATH	
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95. DEATH OF DEATH		96. DEATH OF DEATH		97. DEATH OF DEATH	
98. DEATH OF DEATH		99. DEATH OF DEATH		100. DEATH OF DEATH	

BUREAU V. S.

JAN 6 1900

RECEIVED

Henry B. Lusk, M.D., 1200 N. 1st St., Baltimore, Md.

251  
CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Catonsville</u>				52 TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
00 <u>135 S. Symington Ave.</u>				<u>135 S. Symington Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>EDITH L. ERNSTBERGER</u>				<u>Jan. 11, 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>female</u>	<u>white</u>	<u>married</u>	<u>July 22, 1887</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?
<u>homemaker</u>			<u>at home</u>		<u>Md.</u>		
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>James Ringgold</u>				<u>Lena Gunther</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>no</u>				<u>no</u>		<u>Mr. Charles R. Watson - 2641 Purnell Drive</u>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
443X IMMEDIATE CAUSE (A)						<u>Cerebrovascular Accident</u>	
ANTECEDENT CAUSE (B)						<u>Hypertension C.V.D.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						<u>10 yrs.</u>	
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.						<u>Cardiac enlargement. Arterio-sclerotic Valvular disease</u>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov.</u> , 19 <u>54</u> to <u>Jan.</u> , 19 <u>56</u> that I last saw the deceased alive on <u>Jan. 11</u> , 19 <u>56</u> , and that death occurred at <u>10:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>J. Nelson McKay</u>		<u>6014 Elmwood Ave.</u>		<u>Jan 13, 1956</u>			
M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/14/56</u>		<u>Woodlawn Cem.</u>		<u>Woodlawn, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>January 14 1956</u>		<u>R.W.</u>		<u>Wm. J. Tucker &amp; Sons - Balto.</u>		<u>Md.</u>	

MARGIN RESERVED FOR BINDER

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.







CERTIFICATE OF DEATH

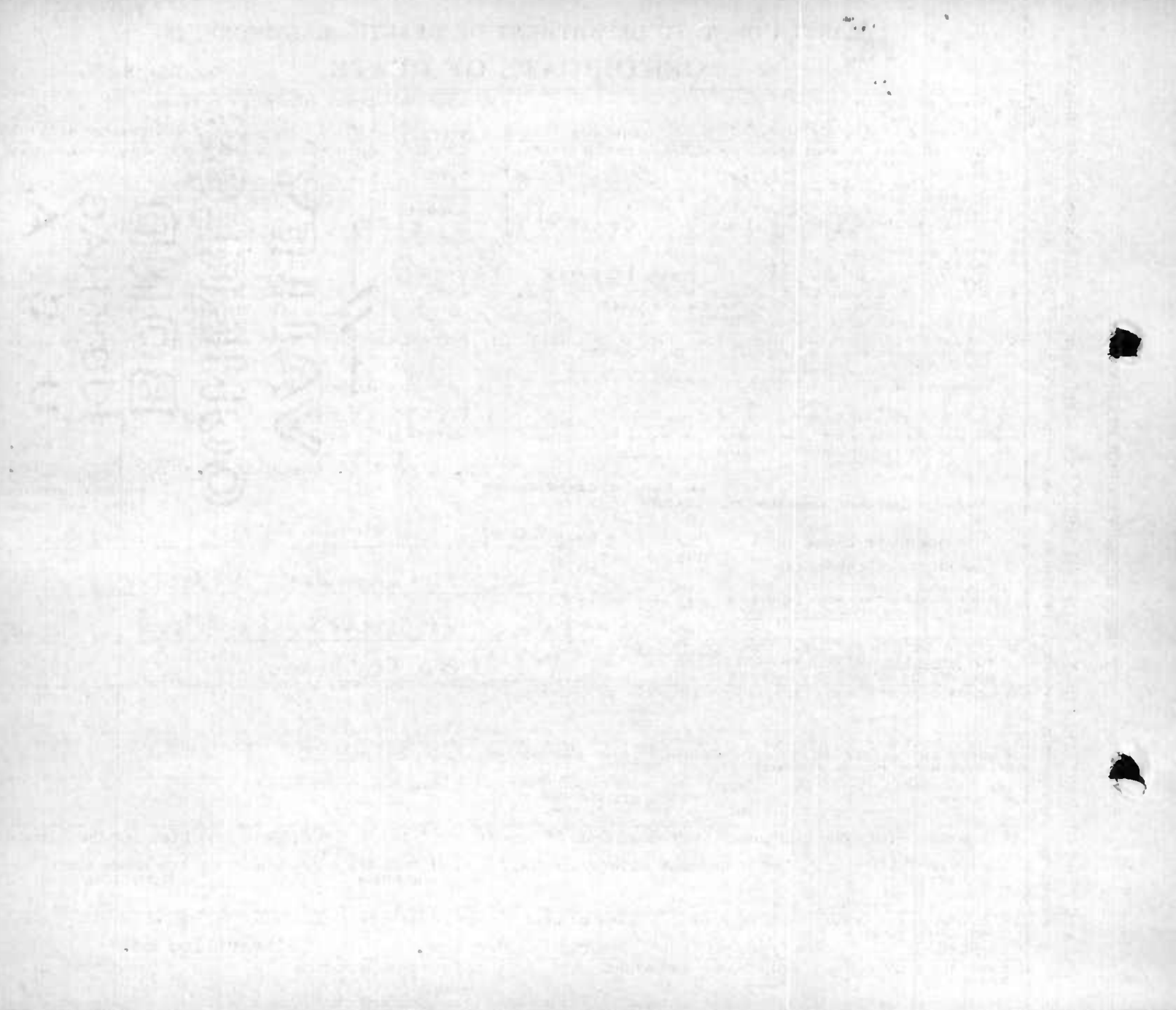
Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore City</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Owings Mills.</u>		LENGTH OF STAY (in this place) <u>2 m. 10 d.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3601-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood Tr. School</u>				STREET ADDRESS (If rural give location) <u>5702 Park Heights Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>David Christopher Farnell</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1 27 1956</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>S</u>	8. DATE OF BIRTH: <u>10-7-55</u>	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 MRS.	
				Yrs. <u>3</u>	Months <u>3</u>	Days <u>30</u>	Hours <u>-</u> Min. <u>-</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>none</u>		11. BIRTHPLACE (State or foreign country): <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Robert E. Farnell</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Agnes Christopher</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>-</u> (If Yes, give war or dates of service) <u>-</u>				16. SOCIAL SECURITY NO. <u>-</u>			
				17. INFORMANT & ADDRESS: <u>Mr. Robert E. Farnell, Jr.-5702 Park Hgts. Ave.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bilateral Pneumonitis</u>						<u>48 hrs.</u>	
ANTECEDENT CAUSE (B) <u>Congenital Cerebral Defect</u>						<u>since birth</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Congenital Heart Condition</u>						<u>since birth</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Malnutrition</u>							
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION <u>-</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>-</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>-</u>			
22. I hereby certify that I attended the deceased from <u>Nov. 17, 1956</u> , to <u>Jan 27, 1956</u> , that I last saw the deceased alive on <u>Jan. 27, 1956</u> , and that death occurred at <u>10 P. M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Viola B. Johns</u>				ADDRESS <u>Owings Mills Md.</u> DATE SIGNED <u>1-28-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>Druid Ridge Cem.</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-30-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Wm. J. Lickner &amp; Sons</u>		ADDRESS <u>17 Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

2146351394



1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

259

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

ITEMS 8,9: film G192  
2-17-56L

## CERTIFICATE OF DEATH

00246

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY (in this place) <u>38 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>26 Enjay Ave.</u>		<u>52</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Paradise Nursing Home</u>				STREET ADDRESS (If rural give location) <u>Catonsville</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>Julia M. Feilinger</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Jan. 31 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>May 12, 1874</u>	9. AGE last birthday <u>81</u> <del>82</del> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Austria</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>--- Heide</u>				14. MOTHER'S MAIDEN NAME <u>Not Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>---</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS <u>Mrs. H. Wilcher 26 Enjay Ave.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>332X IMMEDIATE CAUSE (A) Cerebral thrombosis</u>						<u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO <u>Arteriosclerosis, generalized cerebral Unknown</u>							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1-24</u> , 19 <u>55</u> , to <u>1-31</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-30</u> , 19 <u>56</u> , and that death occurred at <u>2:30 P.</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Stephen Van Heugener</u> M.D.		ADDRESS (Street, city, town, state) <u>Catonsville 28 Md</u>		DATE SIGNED <u>2-2-56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>2-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>Cathedral Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Feb. 6, 1956</u>		REGISTRAR'S SIGNATURE <u>Victor E. Hays</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home Catonsville, Md.</u>			

# CERTIFICATE OF DEATH

REG. ONE 112

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF COUNTY

21. SIGNATURE OF CITY

22. SIGNATURE OF TOWNSHIP

23. SIGNATURE OF PARISH

24. SIGNATURE OF VILLAGE

25. SIGNATURE OF HAMLET

26. SIGNATURE OF CENSUS

27. SIGNATURE OF DISTRICT

28. SIGNATURE OF COUNTY

29. SIGNATURE OF STATE

BUREAU V. S.

FEB 6 1956

RECEIVED

INVESTIGATION

INVESTIGATION OF DEATHS AND CAUSES OF DEATHS  
 The following information is to be filled out by the investigator of the death.  
 1. Name of deceased  
 2. Sex  
 3. Age  
 4. Date of birth  
 5. Place of birth  
 6. Occupation  
 7. Cause of death  
 8. Place of death  
 9. Time of death  
 10. Signature of deceased  
 11. Signature of witnesses  
 12. Signature of physician  
 13. Signature of clerk  
 14. Signature of judge  
 15. Signature of sheriff  
 16. Signature of coroner  
 17. Signature of jury  
 18. Signature of court  
 19. Signature of state  
 20. Signature of county  
 21. Signature of city  
 22. Signature of township  
 23. Signature of parish  
 24. Signature of village  
 25. Signature of hamlet  
 26. Signature of census  
 27. Signature of district  
 28. Signature of county  
 29. Signature of state

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00247

260

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Balto</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fullerton</u>		<u>48 yrs</u>		TOWN <u>Fullerton</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Bucks School House Rd</u>				STREET ADDRESS (If rural give location) <u>Bucks School House Rd</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Otto P Fiedler</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Jan 22 1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH <u>Jan 30-1882</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Himself</u>		9. AGE last birthday <u>73 yrs.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. BIRTHPLACE (State or foreign country) <u>Germany</u>				14. MOTHER'S MAIDEN NAME <u>Emma E Grahl</u>			
13. FATHER'S NAME <u>Ernst W Fiedler</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT & ADDRESS <u>Mrs Minnie Fiedler, Bucks School House Rd</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>422.2</u>				ANTECEDENT CAUSE(S) DUE TO <u>Congestive heart failure</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) <u>Chronic myocarditis 1 yr</u>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. (C) <u></u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>Dec 4</u> <b>19</b> <u>55</u> , <b>to</b> <u>Jan 22</u> <b>19</b> <u>56</u> , <b>that I last saw the deceased alive on</b> <u>Jan 21</u> <b>19</b> <u>56</u> , <b>and that death occurred at</b> <u>11 A.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Rigby</u> <b>ADDRESS</b> (Street, city, town, state) <u>Balto md</u> <b>DATE SIGNED</b> <u>1-23-56</u> M. D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/25/56</u>		NAME OF CEMETERY OR CREMATORY <u>St Peters Luth. Cem</u>		LOCATION (City, town, or county) (State) <u>Balto md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. A. L. Reifrechter</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lassarow Funeral Home</u>		ADDRESS <u>7401 Belair Rd.</u>	
DATE <u>Jan. 24, 1956</u>							



This is to certify that the within and foregoing is a true and correct copy of the original as the same appears in the files of the Bureau of the Census, Department of Commerce, and is hereby certified to be correct and true.

SPECIAL AGENT IN CHARGE

UNITED STATES DEPARTMENT OF COMMERCE  
 BUREAU OF THE CENSUS

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

REG. DIST. NO.

IN WHAT DISTRICT OF MARYLAND

COUNTY

STATE

MARYLAND

DECEASED

AGE

SEX

RACE

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

TIME OF DEATH

DATE OF DEATH

PLACE OF BIRTH

DATE OF BIRTH

SEX OF BIRTH

RACE OF BIRTH

OCCUPATION OF BIRTH

CAUSE OF BIRTH

PLACE OF BIRTH

DATE OF BIRTH

SEX OF BIRTH

RACE OF BIRTH

OCCUPATION OF BIRTH

CAUSE OF BIRTH

BUREAU V. S.

JAN 24 1956



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

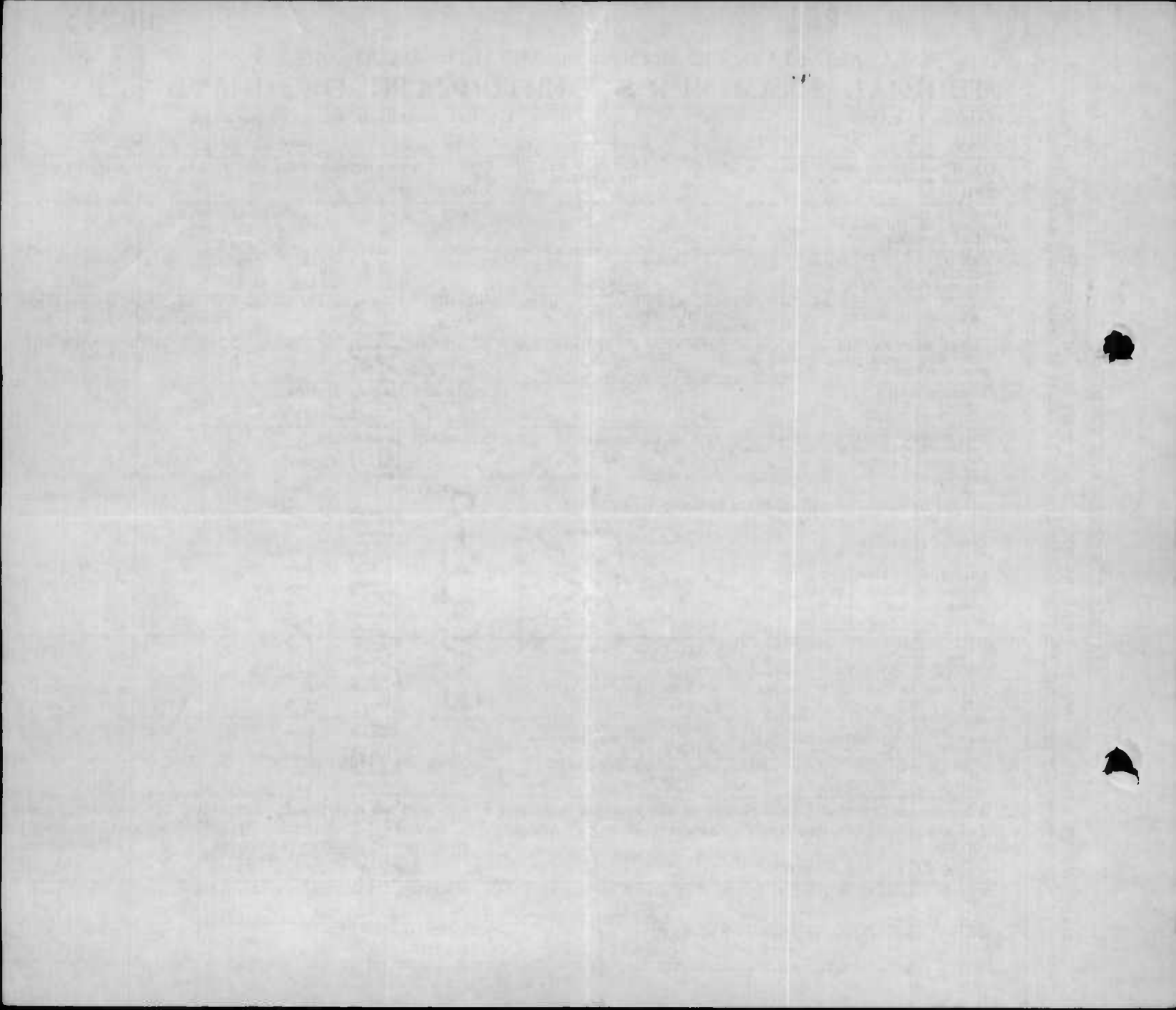
No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Baltr.</i>		MARYLAND		STATE <i>Ind.</i>		COUNTY <i>Baltr. City</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <i>Int. Wilson, Md.</i>		LENGTH OF STAY (in this place) <i>17 hrs</i>		CITY (If outside corporate limits write RURAL and give nearest town) TOWN <i>Baltr.</i>		<i>3401-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Int Wilson Hosp.</i>				STREET ADDRESS <i>1216 Brentwood Ave</i> <i>Baltr.</i>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) <i>HENRY EDWARD FINCH</i>				4. DATE OF DEATH (Month) (Day) (Year) <i>Jan 29 1956</i>			
5. SEX: <i>M.</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>married</i>	8. DATE OF BIRTH: <i>7-17-24</i>	9. AGE last birthday: <i>31</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>City Sanitation Sanitation</i>				10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Baltr., Ind.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				13. FATHER'S NAME: <i>Harry Finch</i>			
14. MOTHER'S MAIDEN NAME: <i>Catherine Hughes</i>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>no.</i>			
16. SOCIAL SECURITY No.: <i>220-14-5288</i>				17. INFORMANT & ADDRESS: <i>Int. Wilson Hosp. Records</i>			

18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						3 1/2 yrs	
Immediate cause (a) <i>Pleural Effusion</i> DUE TO							
Antecedent cause(s) (b) <i>Pulmonary Tbc.</i> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <i>none.</i>		19b. MAJOR FINDING OF OPERATION: <i>none.</i>				20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <i>none.</i>		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY <i>none.</i>		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>none.</i> M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR? <i>none.</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <i>D.D. Caples</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>1-29-56</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>Burial</i>		DATE THEREOF <i>2/1/56</i>		NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cemetery</i>		LOCATION (City, town, or county) (State) <i>Baltimore Maryland</i>	
DATE REC'D BY LOCAL REG. <i>30-56</i>		REGISTRAR'S SIGNATURE <i>Wm. Cook</i>		24. FUNERAL DIRECTOR <i>William Cook Inc.</i>		ADDRESS <i>St. Paul and Beaton Ave 2 Baltimore</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



262

## CERTIFICATE OF DEATH

Reg. Dist. No. 002494

## I. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Spanans Pt. LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md COUNTY Balto.  
 CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Spanans Pt.  
 STREET ADDRESS (If rural, give location) Box 104 Mt. Pt. Rd.

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
THOMAS J. FORBES  
 (Type or Print)

4. DATE OF DEATH: 1 - 5 19 56  
 (Month) (Day) (Year)

## 5. SEX:

M

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

Single

## 8. DATE OF BIRTH:

Mar 10 - 1861

## 9. AGE last birthday:

94 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.  
 Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

FARMER

## 10b. KIND OF BUSINESS OR INDUSTRY:

RETIRED

## 11. BIRTHPLACE (State or foreign country):

Va.

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

Angus Forbes

## 14. MOTHER'S MAIDEN NAME:

Unknown

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

Bertie Swisher (Same)

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

## Immediate cause

(a) DUE TO

Arteriosclerosis Ht. Disease

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

Generalized Arteriosclerosis

(c)

INTERVAL BETWEEN ONSET AND DEATH

4 yrs

10 yrs

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.)  
 INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)  
 OF INJURY

INJURY OCCURRED  
 While at Not while  
 work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 5, 1953, to Jan, 1956, that I last saw the deceased alive on Jan 5, 1956, and that death occurred at 2:00 P.M., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

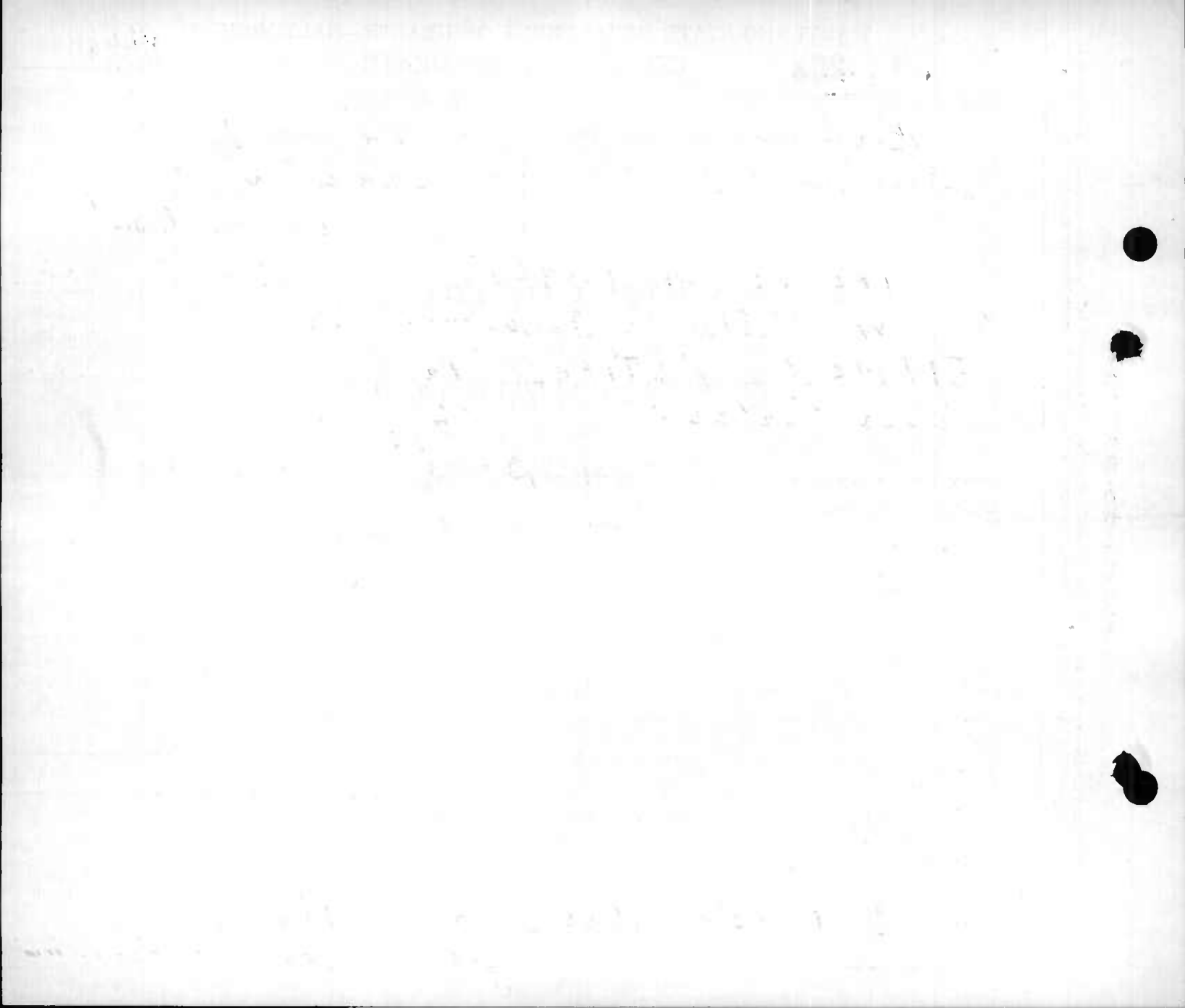
REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

John G. Connelly, Esq. Md.

MARGIN RESERVED FOR BINDING



263

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Fort Howard</b>		LENGTH OF STAY in this place <b>17 days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>		STREET ADDRESS (If rural give location) <b>130 N. Carlton Street</b>					
3. NAME OF DECEASED: (Type or Print) <b>WILLIAM</b>		(First) (Middle) (Last) <b>FORD</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>January 1 1956</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Negro</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>10/2/02</b>	9. AGE last birthday <b>53</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Helper</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Transfer Co.</b>		11. BIRTHPLACE (State or foreign country): <b>Prospect, Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>Unknown</b>				14. MOTHER'S MAIDEN NAME: <b>Betty (Middle name unknown)</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>Yes</b>		(If Yes, give war or dates of service) <b>WW I</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT & ADDRESS: <b>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A)		DUE TO <b>BRONCHOGENIC CARCINOMA LEFT UPPER LOBE</b>				UNKNOWN	
ANTECEDENT CAUSE (B)		DUE TO <b>WITH METASTASES TO ADRENALS</b>					
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <b>VA</b> attended the deceased from <b>Dec 15, 1955</b> , to <b>Jan 1, 1956</b> , and that death occurred at <b>5:30A</b> M., from the causes and on the date stated above.							
SIGNATURE <b>DONALD D. MARK</b>		M. D. <b>Fort Howard, Md.</b>		DATE SIGNED <b>1/2/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/6/55</b>		NAME OF CEMETERY OR CREMATORY <b>Sulphur Spring Baptist Church Cemetery</b>		LOCATION (City, town, or county) (State) <b>Prospect, Va.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
SHIPPED TO: <b>Bland Funeral Home, 412 Ely St., Baltimore, Md.</b>				<b>Charles R. Law Funeral Home</b>		<b>802-04 Madison Ave., Balto, Md.</b>	

MARGIN RESERVED FOR BINDING

V.S. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

40530

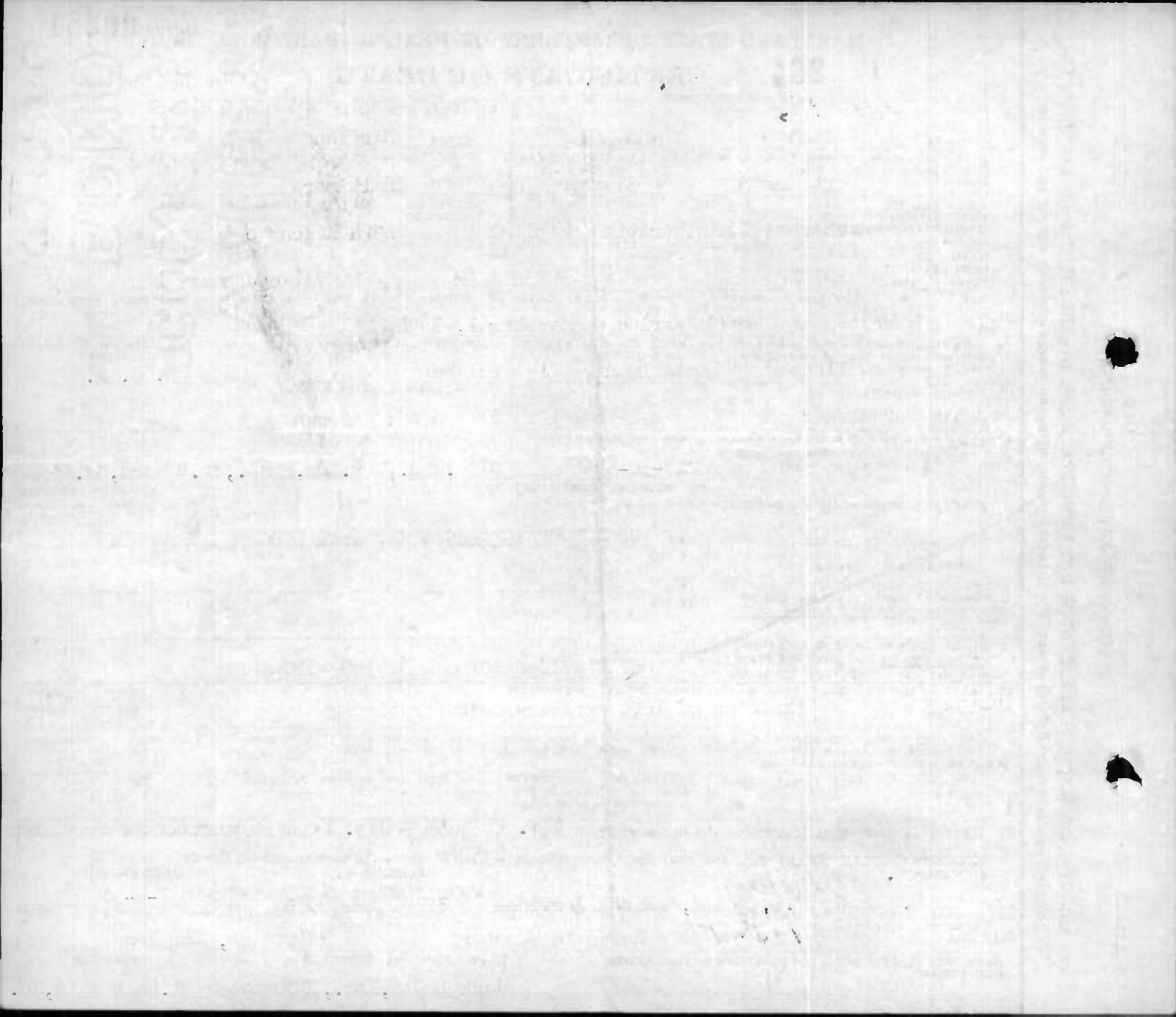
RECEIVED

523

TO THE DIRECTOR, BUREAU OF REVENUE  
WASHINGTON, D. C.  
FROM THE COMMISSIONER, BUREAU OF INTERNAL REVENUE  
JANUARY 10, 1917  
SUBJECT: [Illegible]  
[The remainder of the document contains several paragraphs of extremely faint, illegible text, likely a memorandum or official correspondence.]







1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00252

265

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CATON Ridge HOME MARYLAND</u>				STATE <u>MARYLAND</u> COUNTY <u>Balto</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>(28) BALTIMORE</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CATON Ridge Nursing Home.</u>				STREET ADDRESS (If rural give location) <u>1909 Victory Drive (27)</u>			
3. NAME OF DECEASED (Type or Print) <u>ALFRED M. FOWLER JR.</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>JAN. 4, 1956</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>		8. DATE OF BIRTH <u>April 6, 1905</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>KEPPERS CO.</u>		9. AGE last birthday <u>50</u> yrs.		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>ALFRED M. FOWLER SR.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>—</u> (If Yes, give war or dates of service) <u>—</u>				14. MOTHER'S MAIDEN NAME <u>LILLIE M. LEWIS</u>		17. INFORMANT & ADDRESS <u>Mrs. Mabel L. Fowler (27)</u>	
16. SOCIAL SECURITY NO. <u>216-05-5213</u>				18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
331X IMMEDIATE CAUSE (A) <u>Cerebrovascular Hemorrhage -</u>				<u>6 hr.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>hypertension severe</u>				<u>Death due</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>—</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>—</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 4, 1955</u> , to <u>Jan 7, 1956</u> , that I last saw the deceased alive on <u>Jan 4, 1956</u> , and that death occurred at <u>4:35</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Cliff Roney</u>				ADDRESS (Street, city, town, state) <u>4605 Edmondson Ave. Jct 6, 1948</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>ELLEN HAVEN CEM.</u>		LOCATION (City, town, or county) (State) <u>ELLEN BORNIE Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 9, 1956</u>		REGISTRAR'S SIGNATURE <u>T. E. Roney</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>E. Truman Schuch</u>		ADDRESS <u>3512 Frederick Ave. (29)</u>	

10000

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. Name of deceased

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Date of death

7. Place of death

8. Cause of death

9. Duration of illness

10. Name of physician

11. Name of funeral director

12. Name of undertaker

13. Name of cemetery

14. Name of burial place

15. Name of interment

16. Name of monument

17. Name of grave

18. Name of lot

19. Name of block

20. Name of section

21. Name of row

22. Name of column

23. Name of corner

24. Name of side

25. Name of end

26. Name of base

27. Name of top

28. Name of bottom

29. Name of front

30. Name of back

BUREAU V. S.

JAN 9 1900

RECEIVED

265

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Riderwood</u>				TOWN <u>Baltimore</u>		<u>31014</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Soremen Nursing Home 7912 Rexway Road.</u>				STREET ADDRESS (If rural give location) <u>unknown</u>			
3. NAME OF DECEASED: (First) <u>Matthew</u> (Middle) <u>Fox</u> (Last) <u>Fox</u>				4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>14</u> (Year) <u>1956</u>			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>unknown</u>		8. DATE OF BIRTH: <u>unknown</u>	
9. AGE last birthday: <u>86</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>unknown</u>		11. BIRTHPLACE (State or foreign country): <u>unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u>		16. SOCIAL SECURITY No.: <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Soremen Nursing Home</u>			

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
Immediate cause (a) <u>myocarditis Chronic with Distention</u>		<u>5 years</u>	
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>Hypertrophy myocardium &amp; failure</u>		<u>1 day</u>	
(c) <u>Suppurative prostatitis</u>		<u>6 months</u>	
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Valvular disease Chronic Cardiac Mitral</u>		<u>5 years</u>	
19a. DATE OF OPERATION: <u>unknown</u>		19b. MAJOR FINDINGS OF OPERATION: <u>Enlarged Prostate</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>		PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no injury</u>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Oct 10, 1955</u> , to <u>Jan 14, 1956</u> , that I last saw the deceased alive on <u>Jan 14, 1956</u> , and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James Graham Munton MD</u>		ADDRESS <u>516 Cathedral St.</u>	
DATE SIGNED <u>Jan 14, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>JAN 30 1956</u>		NAME OF CEMETERY OR CREMATORY <u>JOHNS HOPKINS MEDICAL SCHOOL</u>	
DATE REC'D BY LOCAL REGISTRAR <u>JAN 30 1956</u>		REGISTRAR'S SIGNATURE <u>Huntington Williams, MD</u>	
24. FUNERAL DIRECTOR <u>Huntington Williams, MD</u>		ADDRESS <u>Huntington Williams, MD</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

V95-7010

BUREAU V. S.

FEB 6 1956

RECEIVED



**INSTRUCTIONS**  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

267

CERTIFICATE OF DEATH

00254

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Fort Howard</u>		<u>3 Days</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>4837 Hazelwood Avenue</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>HENRY</u> (First) <u>FRANKENBERGER</u> (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>January 5</u> <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>March 22, 1888</u>	
9. AGE last birthday <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		11. BIRTHPLACE (State or foreign country) <u>Raspeburge, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Henry Frankenger</u>				14. MOTHER'S MAIDEN NAME <u>Wilehmina Klingler</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>218-32-0405</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH <u>1 YEAR</u>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)			
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)				21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) 21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			
21f. HOW DID INJURY OCCUR?				22. I hereby certify that I attended the deceased from <u>Jan. 2</u> , 19 <u>56</u> , to <u>Jan. 5</u> , 19 <u>56</u> , and that death occurred at <u>2:00 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Donald D. Mark, M. D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>1/5/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR <u>1/9/56</u> REGISTRAR'S SIGNATURE <u>Lassahn</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn</u>				ADDRESS <u>Lassahn Funeral Home, 7401 Belair Rd. Balto. Md.</u>			

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 268 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00255

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

Item 2, Film G191 1-18-56 et

1. PLACE OF DEATH: <u>Rosewood State Training School</u>		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Md.</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Owings Mills -</u>	LENGTH OF STAY (in this place) <u>7.25.53</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>FALL HAVEN Del Air</u>	<u>1232.2</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Rosewood State Training School -</u>		STREET ADDRESS <u>118 S. Main Street</u> <u>911 Alms House</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Marguerite - Fuhrman</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>1 . 1 . 1956</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <u>2. 8. 1914</u>
9. AGE last birthday <u>41</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Md.</u>
13. FATHER'S NAME: <u>Harry F. Fuhrman</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth M. Fike</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT & ADDRESS: <u>Harford Co. Commission</u> <u>Mr. T. Leo Sullivan</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>500X</u> <u>Acute Bronchitis with</u>		<u>1 day</u>	
ANTECEDENT CAUSE (S) <u>260X</u> <u>Bronch. Pneumonia and</u>		<u>1 day</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		(B) <u>Diabetes Mellitus - (unknown)</u>	
(C) <u>congenital cerebral malformation of brain with symptomatic Epilepsy</u>		<u>Birth</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>31 Dec, 1955</u> , to <u>1 Jan, 1956</u> , that I last saw the deceased alive on <u>1 Jan, 1956</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.			
SIGNATURE <u>Harry B. Butler</u>		M. D. <u>Owings Mills, Md 1/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 3/56</u>	
NAME OF CEMETERY OR CREMATORY <u>St Ignatius</u>		LOCATION (City, town, or county) (State) <u>Hickory Hartford Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1956</u>		24. FUNERAL DIRECTOR <u>Antonia Funeral Home, Inc. W. Fritz Baltimore, Md.</u>	

BUREAU V. S.

JAN 5 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

269

## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hebbville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Hebbville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7212 Windsor Mill Road</u>		STREET ADDRESS (If rural, give location) <u>7212 Windsor Mill Road</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Charles</u>	(Middle) <u>P.</u>	(Last) <u>Garriott</u>
4. SEX <u>Male</u>	5. COLOR OR RACE <u>White</u>	6. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	7. DATE OF BIRTH <u>Jan. 19 1870</u>
8. AGE last birthday <u>85</u> yrs.	9. DATE OF DEATH <u>Jan. 4th 1956</u>	10. MONTHS <u>19</u>	11. DAYS <u>56</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>	
11. BIRTHPLACE (State or foreign country) <u>Erie, Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles A. Garriott</u>		14. MOTHER'S MAIDEN NAME <u>Frances Royce</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs Wm. Roherer, 7212 Windsor Mill Road</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH <u>— ?</u>
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>177x Exposure to Asbestos</u>		
Antecedent cause(s) (b) <u>Insufficiency of eye</u>		
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>—</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

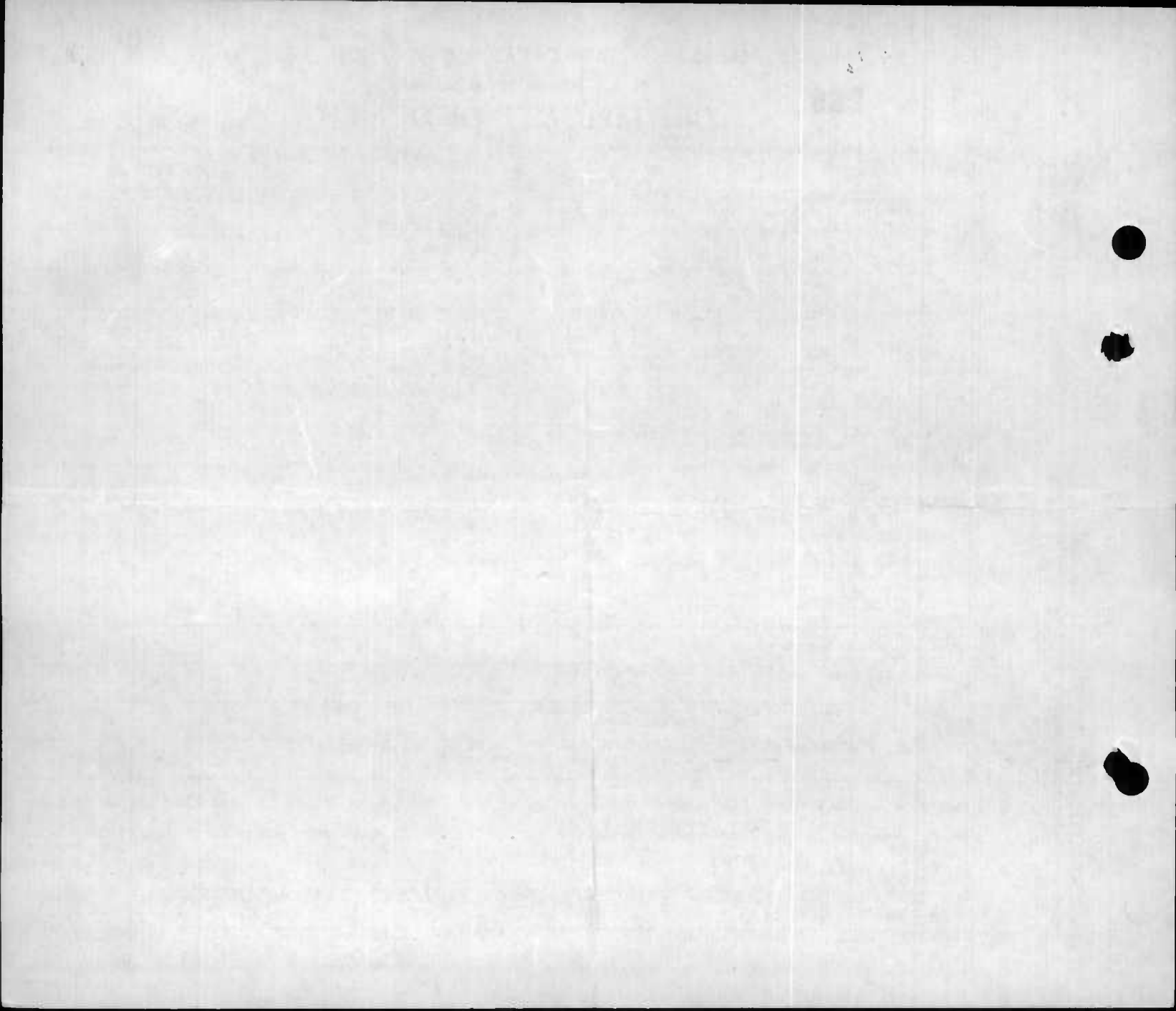
22. I hereby certify that I attended the deceased from Dec 1-7, 1955, to Jan 2, 1956, that I last saw the deceased alive on Jan 3, 1956, and that death occurred at 4:30 A.M., from the causes and on the date stated above.

SIGNATURE <u>Dr. Thos. G. Roberts</u>	(Degree or title)	ADDRESS <u>4509 Liberty Heights Ave.</u>	DATE SIGNED <u>Jan. 4th/56</u>
23. BURIAL, CREMATION, REMOVAL (Specify)	DATE THEREOF <u>Jan. 6th 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Mt. Olive Cemetery</u>	LOCATION (City, town, or county) (State) <u>Randallstown, Balto Md</u>
DATE REC'D BY LOCAL REG. <u>1/4/56</u>	REGISTRAR'S SIGNATURE <u>A. H. Hecht</u>	24. FUNERAL DIRECTOR <u>Stella Lawrence</u>	ADDRESS <u>4510 Lib Heights Ave.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





CERTIFICATE OF DEATH

Reg. Dist. No.

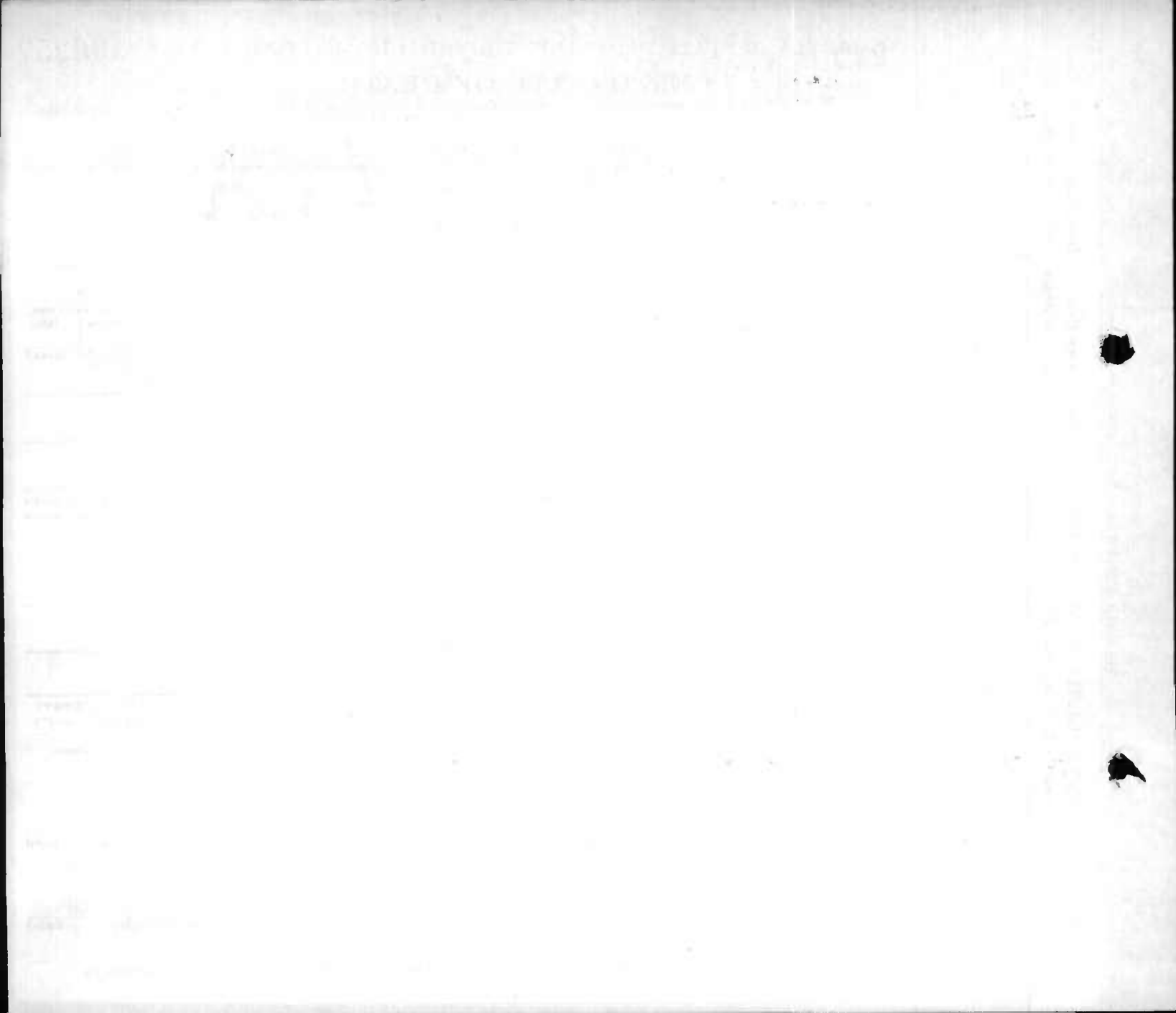
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MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAIN INK. Every item of information should be carefully supplied. correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. NAME OF DECEASED (Type or Print) <i>Elmer V. Garrity</i>			2. DATE OF DEATH <i>Jan. 14, 1956</i>		
3. PLACE OF DEATH: A. Baltimore City, Maryland <i>2100. Smith Ave</i>			4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		
B. FULL NAME OF HOSPITAL OR INSTITUTION <i>2100 Smith Ave Baltimore, Md</i>			C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) <i>Baltimore</i>		
C. Length of stay in Baltimore <i>Life</i> Yrs. Mos. Days			D. STREET ADDRESS (If rural, give location) <i>2100 - Smith Ave</i>		
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>married</i>	8. DATE OF BIRTH <i>Jan. 12, 1912</i>	9. AGE (In years last birthday) <i>43</i>	10. Under 1 Year Months: Days
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Steamfitter</i>			10B. KIND OF BUSINESS OR INDUSTRY		
11. BIRTHPLACE (State or foreign country) <i>Baltimore, Md</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		
13. FATHER'S NAME <i>William Garrity</i>			14. MOTHER'S MAIDEN NAME <i>Mary Brooks</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>213-05-7745</i>	17. INFORMANT ADDRESS <i>Julia Garrity, 2100 - Smith Ave, Baltimore</i>		
18. <i>420.1</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e. g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH		
ANTECEDENT CAUSES			INTERVAL BETWEEN ONSET AND DEATH		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.			(A) <i>Coronary Occlusion</i> <i>24 hours</i>		
			(B) <i>Coronary Heart Disease</i> <i>2</i>		
			(C) <i>possibly about 1 or 2 years</i>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH, BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>Jan 14, 1956</i> to <i>Jan 14, 1956</i> , that I last saw the deceased alive on <i>Jan 14, 1956</i> and that death occurred at <i>12:45 PM</i> from the causes and on the date stated above.					
23A. SIGNATURE <i>Leonard Wallenstein</i>		23B. ADDRESS <i>848 W 36th St</i>		23C. DATE SIGNED <i>1/16/56</i>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>Jan. 18, 1956</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Druid Ridge</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Md</i>		(State)			
DATE RECEIVED BY LOCAL REGISTRAR <i>1/16/56</i>		REGISTRAR'S SIGNATURE <i>C. W. Stedrich</i>		25. FUNERAL DIRECTOR ADDRESS <i>Carl B. Wolberton Funeral Home, Inc</i>	



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

271

## CERTIFICATE OF DEATH

00258

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Balto</u>		STATE <u>Md</u> COUNTY <u>Balto</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		LENGTH OF STAY (in this place) <u>6 months</u>		TOWN <u>Baltimore</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Caton Ridge Nursing Home</u>				STREET ADDRESS (If rural give location) <u>3904 W. Cold Spring Lane</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>George C. T. Gilbert</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1 20 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Aug 13, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Rest. Serv. Bus</u>		11. BIRTHPLACE (State or foreign country) <u>Penna</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Chas. Gilbert</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>218-32-7546</u>		17. INFORMANT & ADDRESS <u>Mrs. Elmer M. Honeysuckle 2714 Rd. 2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac failure</u>				<u>27 hrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Arterio sclerosis</u>				<u>Unknown</u>			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Oct 19, 1955</u> to <u>Jan 20, 1956</u> , that I last saw the deceased alive on <u>Jan 19, 1956</u> , and that death occurred at <u>9:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Chas. Gilbert</u> M.D. <u>4665 Edmondson Ave</u>				DATE SIGNED <u>1/21/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/23/56</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial</u>		LOCATION (City, town, or county) <u>Balto. Md</u>	
24. REGD BY REGISTRAR <u>Jan. 24, 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Loring Byars</u>		ADDRESS <u>5005 Pk. Hyatt Balto 15, Md</u>	

# CERTIFICATE OF DEATH

Registration No.

1. NAME OF DECEASED (Print Name and Surname)

2. SEX AND

3. PLACE OF BIRTH

4. AGE

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESS

14. SIGNATURE OF DECEASED

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. SIGNATURE OF WITNESS

18. SIGNATURE OF DECEASED

19. SIGNATURE OF PHYSICIAN

20. SIGNATURE OF REGISTRAR

21. SIGNATURE OF WITNESS

22. SIGNATURE OF DECEASED

23. SIGNATURE OF PHYSICIAN

24. SIGNATURE OF REGISTRAR

25. SIGNATURE OF WITNESS

26. SIGNATURE OF DECEASED

27. SIGNATURE OF PHYSICIAN

28. SIGNATURE OF REGISTRAR

29. SIGNATURE OF WITNESS

30. SIGNATURE OF DECEASED

NOTIFICATION

1. A copy of this certificate shall be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy shall be sent to the office of the Registrar of the County or City in which the death occurred.

BUREAU V. A.

JAN 25 1955

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

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# CERTIFICATE OF DEATH

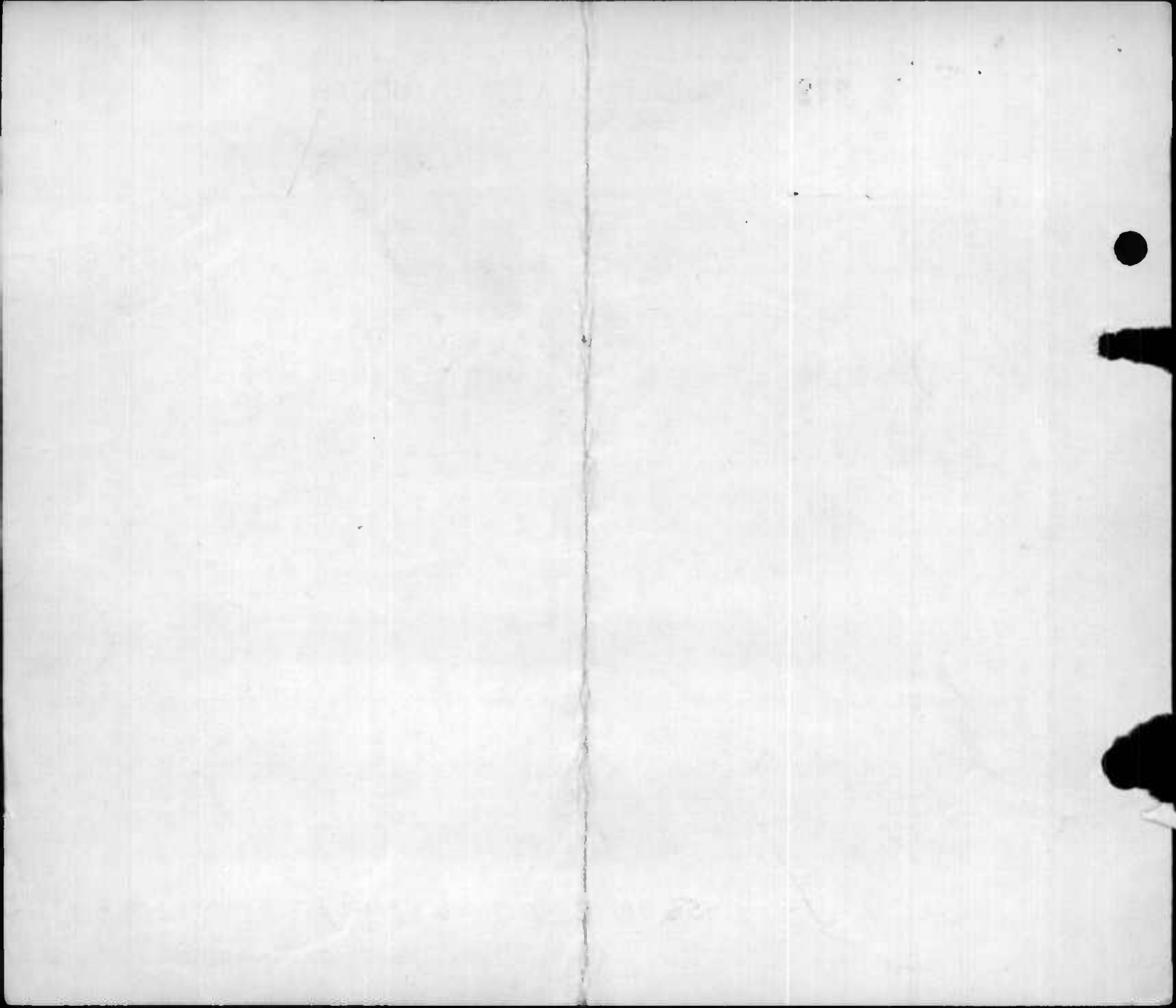
## FOR MEDICAL EXAMINERS

Reg. Dist. No. *44*

1. PLACE OF DEATH COUNTY <i>Baltimore</i>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <i>MD.</i> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>Spawns Pt.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>BALTIMORE.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Beth Steel Dispensary</i>		STREET ADDRESS (If rural, give location) <i>420 S. NEWKIRK ST.</i>	
3. NAME OF DECEASED (Type or Print) <i>Paul</i> (First) <i>Michael</i> (Middle) <i>Goecke</i> (Last)		4. DATE OF DEATH <i>1-20</i> (Month) <i>1956</i> (Year)	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <i>MARRIED</i>	8. DATE OF BIRTH <i>MAR. 11, 1913</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>CHECKER</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>BETH STEEL CO.</i>	11. BIRTHPLACE (State or foreign country) <i>BALTIMORE, MD.</i>
13. FATHER'S NAME <i>OTTO GOECKE</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <i>YES. W.W.II</i>		14. MOTHER'S MAIDEN NAME <i>JUSTINE ROHLEDER.</i>	
16. SOCIAL SECURITY No.		17. INFORMANT AND ADDRESS <i>LILLIAN GOECKE SAME.</i>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <i>912.3</i> Immediate cause (a) <i>Compound Fracture of Skull - frontal</i> Antecedent cause(s) (b) <i>Regimen, just above + lateral to eye</i> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <i>None</i>			INTERVAL BETWEEN ONSET AND DEATH
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <i>1-20-56</i>		19b. MAJOR FINDINGS OF OPERATION	
21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		PLACE (Home, farm, factory, street, or office, etc.) OF INJURY <i>Spawns Pt. Balts. Md.</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>1-20-56-4:45</i> m.		INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR? <i>Head was caught between crane &amp; furnace</i>	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <i>W. G. Davis M.D.</i>		DATE SIGNED <i>1/20/56</i>	
23. BURIAL, CREMATION REMOVAL (Specify) <i>BURIAL</i>		DATE THEREOF <i>1-24-56</i>	
NAME OF CEMETERY OR CREMATORY <i>BALTO. NATIONAL CEM.</i>		LOCATION (City, town, or county) (State) <i>5501 FREDERICK AVE. BALTO. MD.</i>	
DATE REC'D BY LOCAL REG. <i>1/23/56</i>		24. FUNERAL DIRECTOR <i>Charles S. Zeiler</i> ADDRESS <i>901 S. CONKLING ST. BALTO., MD.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





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## MARYLAND STATE DEPARTMENT OF HEALTH

00260

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Pikesville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>4 Salem Court</u>	
3. NAME OF DECEASED (First) (Middle) (Last) <u>Jeanette</u> <u>Goldberg</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January 17, 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>1905</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
		17. INFORMANT AND ADDRESS <u>Records Spring Grove State Hospital</u>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause <u>Pulmonary abscesses</u>	(a)	<u>Unk.</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(b)	<u>Unk.</u>
	(c)	

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Fracture of right hip</u>		Approx <u>5wks.</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>

21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) INJURY <u>Home</u>	(CITY OR TOWN) <u>Pikesville</u>	(COUNTY) <u>Baltimore Md.</u>	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Approx. 12-20-55 4A.m.</u>	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>Unknown. Family states she fell while at home.</u>			

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☒, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE <u>Dr. M. Kieffer</u>		ADDRESS <u>1010 Leeds Ave</u>	DATE SIGNED <u>1-17-56</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Jan 18 1956</u>	NAME OF CEMETERY OR CREMATORY <u>Arbutus, Maryland</u>
DATE REC'D BY LOCAL REG. <u>1-18-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>1124-26 N. North Ave</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Memorandum

to the President

of the

Advisory

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00261

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## CERTIFICATE OF DEATH

Reg. Dist. No. 35

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Sharks Rural Life</u>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Sharks Rural</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Mount Carmel</u>				STREET ADDRESS (If rural give location) <u>Mt. Carmel</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) (First) (Middle) (Last) <u>LEWIS ALBERT GORSUCH</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>JANUARY 8 1956</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>widower</u>	<b>8. DATE OF BIRTH</b> <u>JULY 30, 1860</u>	<b>9. AGE last birthday</b> <u>95</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days	<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>agriculture</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Benjamin Gorsuch</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Shamburger</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>This Grace Miller, Sparks Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b> <u>422.1</u>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE (A)</b> <u>Chronic Myocarditis</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Arterio-sclerotic Cardio-Vascular disease</u>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 8, 1956, to Jan 8, 1956, that I last saw the deceased alive on Jan 8, 1956, and that death occurred at 11:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Joseph E. Bush</u> M.D.				<b>ADDRESS</b> (Street, city, town, state) <u>Towson, Md.</u>			
<b>DATE SIGNED</b> <u>Jan 8, 1956</u>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>Jan. 11, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Carmel Cemetery</u>		<b>LOCATION (City, town, or county)</b> (State) <u>Mt. Carmel, Balto., Co., Md.</u>	
<b>24. REG'D BY REGISTRAR</b> DATE <u>1-12-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mrs. Howard S. Mankline</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John Burns' Sons</u>		<b>ADDRESS</b> <u>Towson, Md.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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## CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>52 TOWN Catonsville</b>	LENGTH OF STAY (in this place) <b>1 week</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Reisterstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>90 16 Fusting Avenue</b>		STREET ADDRESS (If rural give location) <b>Nicodemus Road</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Joseph Milton Gosnell</b>		4. DATE (Month) (Day) (Year) OF DEATH: <b>1 13 1956</b>	
5. SEX: <b>M</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Single</b>	8. DATE OF BIRTH: <b>April - 1872</b>
9. AGE last birthday <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Farmer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Self employed</b>	
11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>George W Gosnell</b>		14. MOTHER'S MAIDEN NAME: <b>Keziah E Gosnell</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT & ADDRESS: <b>Daniel Phillips Reisterstown Md</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <b>442X</b>			
ANTECEDENT CAUSE (S):		(A) <b>Acute Cardiac Dilatation</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) <b>Hypertensive Cardio-Vascular Disease</b>	
		(C) <b>Chronic Hydronephrosis &amp; Hydronephrosis</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
22. I hereby certify that I attended the deceased from <b>1-6</b> , 1956, to <b>1-13</b> , 1956, that I last saw the deceased alive on <b>1-13</b> , 1956, and that death occurred at <b>5:30 P.M.</b> , from the causes and on the date stated above.			
SIGNATURE <b>William K. Gallagher</b>		ADDRESS <b>M.D. 6209 Frederick Ave. Ball 25</b>	
DATE SIGNED <b>1-13-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jan 16 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Reisterstown Meth Cem</b>		LOCATION (City, town, or county) <b>Reisterstown Md</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1-15-56</b>		REGISTRAR'S SIGNATURE <b>Mary B. E. [unclear]</b>	
24. FUNERAL DIRECTOR <b>Wm Berryman &amp; Sons</b>		ADDRESS <b>Reisterstown Md</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 19 1956

BUREAU V. S.



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## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto.</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Balto.</b>
CITY (If outside corporate limits, write RURAL and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)	
<input checked="" type="checkbox"/> TOWN <b>Gray Manor</b>		OR TOWN <b>Gray Manor</b>	<input checked="" type="checkbox"/>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>7 N. Point Terrace</b>		STREET ADDRESS (If rural give location)	<b>7 N. Point Terrace</b>
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH:	
(First) <b>Maxam</b>	(Middle) <b>L</b>	(Last) <b>Goudy</b>	(Month) <b>Jan. 14,</b> (Day) <b>19</b> (Year) <b>56</b>
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>September 11, 1911</b>
9. AGE last birthday: <b>44</b> yrs.		10. IF UNDER 1 YEAR: Months <b>44</b> Days <b>44</b> Hours <b>44</b> Min. <b>44</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Solicitor</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Freight Co.</b>	
11. BIRTHPLACE (State or foreign country): <b>Baltimore md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>Notley Goudy</b>		14. MOTHER'S MAIDEN NAME: <b>Jessie Browne</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>no</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT & ADDRESS: <b>Mrs. Elda Goudy - 7 N. Point Terr.</b>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>Cerebral Hemorrhage</b>			
ANTECEDENT CAUSE (S) DUE TO (B) <b>Malignant Hypertension</b>			<b>3 months</b>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Uremia</b>			<b>3 months</b>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>Nov. 16, 1955</b> to <b>Jan. 14, 1956</b> that I last saw the deceased alive on <b>Jan. 11, 1956</b> , and that death occurred at <b>5 P. M.</b> from the causes and on the date stated above.			
SIGNATURE <b>John C. Moran M.D.</b>		ADDRESS <b>M. D. Gray Manor Med. Centre</b> DATE SIGNED <b>1/14/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1.18.56</b>	
NAME OF CEMETERY OR CREMATORY <b>Woodlawn Cem.</b>		LOCATION (City, town, or county) (State) <b>Woodlawn, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1-16-56</b>		REGISTRAR'S SIGNATURE <b>John C. Moran</b>	
FUNERAL DIRECTOR <b>Thos. J. Siskewer &amp; Sons - Balto 17 Md.</b>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore County</u> MARYLAND	STATE <u>Md.</u> COUNTY <u>Carroll</u>		
CITY (If outside corporate limits, write RURAL OR and give nearest town)	CITY (If outside corporate limits write RURAL and give nearest town)		
TOWN <u>Randallstown</u>	TOWN <u>Gett</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS	STREET ADDRESS (If rural, give location)		
		<u>Hydenville R.D. #3 P.O.</u>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>Curry</u>	(Middle) <u>Lee</u>	(Last) <u>Graybeal</u>	(Month) <u>1</u> (Day) <u>7</u> (Year) <u>1956</u>
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>	
7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>Single</u>		8. DATE OF BIRTH: <u>Nov. 3, 1955</u>	
9. AGE last birthday: <u>2</u> yrs.		10. IF UNDER 1 YEAR: Months <u>2</u> Days <u>4</u> Hours <u>4</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>none</u>	
11. BIRTHPLACE (State or foreign country): <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Carl Graybeal</u>		14. MOTHER'S MAIDEN NAME: <u>Kate Horner</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT & ADDRESS: <u>Carl Graybeal - Hydenville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
391.2 Immediate cause (a) <u>Obv. media</u> DUE TO		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO		
stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .					
SIGNATURE <u>William V. Smith</u>		CHIEF MEDICAL EXAMINER		DATE SIGNED <u>1-7-56</u>	
23. BURIAL, CREMATION, REMOVAL, (Specify): <u>Burial</u>		DATE THEREOF <u>1-9-56</u>		NAME OF CEMETERY OR CREMATORY <u>Bethesda</u>	
LOCATION (City, town, or county) (State) <u>Shot, Carroll, Md.</u>		24. FUNERAL DIRECTOR		ADDRESS <u>Wm. E. Martin</u>	
DATE REC'D BY LOCAL REG. <u>Jan. 8, 1956</u>		REGISTRAR'S SIGNATURE			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JAN 17 1956

RECEIVED

278

## CERTIFICATE OF DEATH

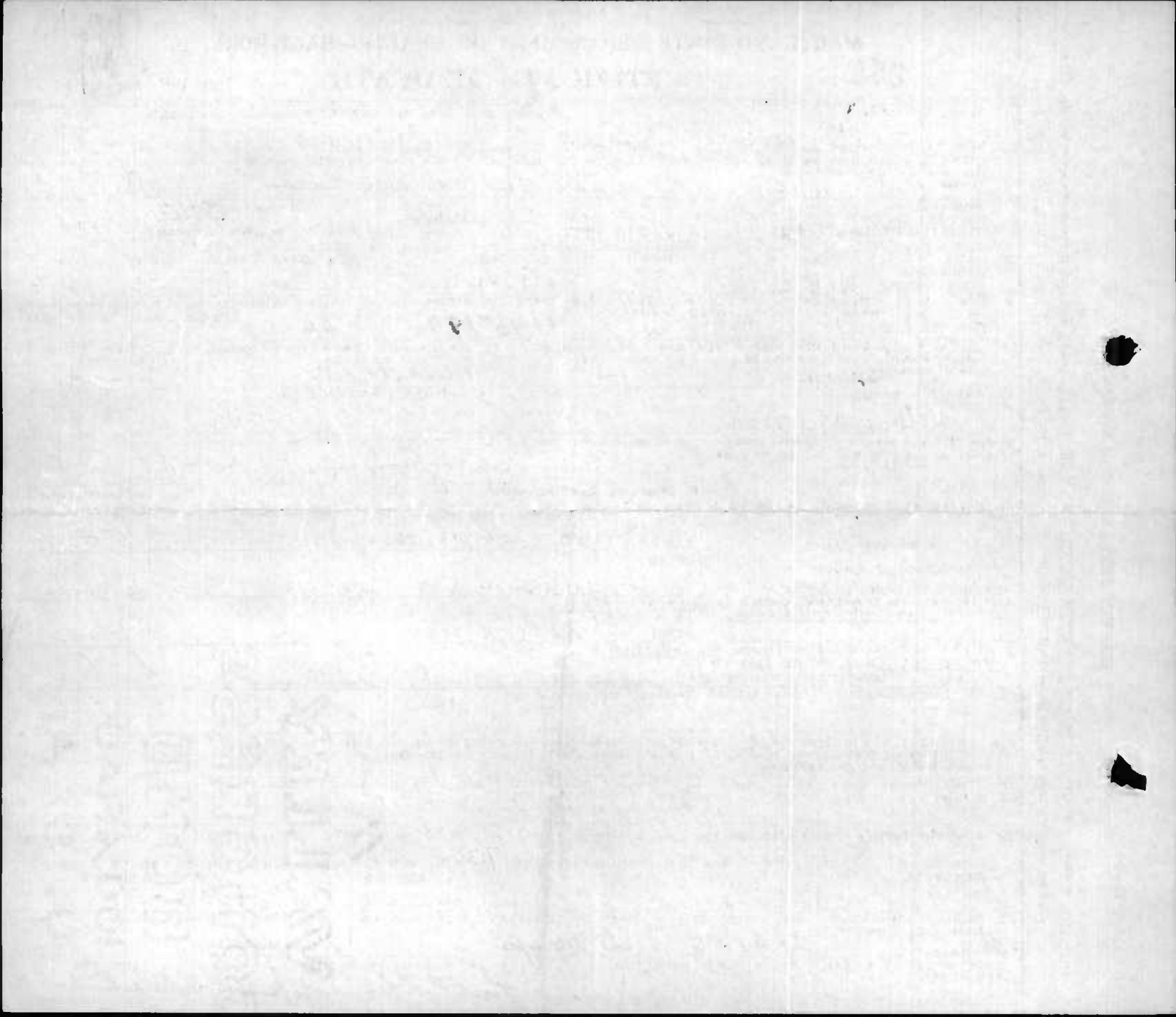
Reg. Dist. No.

30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Cabinville</u>		LENGTH OF STAY (in this place) <u>2 yrs. 6 m. 15 d</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		COUNTY <u>Marley Park, Md</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>				STREET ADDRESS (If rural give Station Road) <u>Marley Park, Md.</u>			
3. NAME OF DECEASED: (First) <u>Nellie</u> (Middle) <u>C</u> (Last) <u>Green</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1</u> <u>30</u> <u>1956</u>			
5. SEX: <u>F.</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W.</u>	8. DATE OF BIRTH: <u>4/15/89</u>	9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Spinner</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>—</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Wilbur Martin</u>				14. MOTHER'S MAIDEN NAME: <u>Ella</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>—</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT & ADDRESS: <u>Spring Grove Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Cerebral hemorrhage</u>						<u>5 days</u>	
ANTECEDENT CAUSE (B) <u>Hypertensive C.V. disease</u>						<u>unknown</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Pneumonia; Broncho</u>						<u>3 days</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July 15</u> , 19 <u>53</u> , to <u>Jan 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 30</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M, from the causes and on the date stated above.							
SIGNATURE <u>L. Shupe Williams</u>				ADDRESS <u>M.D. Spring Grove State Hosp 1-30-56</u>			
23. BURIAL CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/2/56</u>		NAME OF CEMETERY OR CREMATORY <u>St Mary's</u>		LOCATION (City, town, or county) (State) <u>Hampden</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-1-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Paul E. Chmanoff</u>		ADDRESS <u>3615-7 Chestnut Ave</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

00266

Reg. Dist. No. 44

279

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>8 Days</b>		TOWN <b>BALTIMORE</b>		<b>3Y01-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1916 PATTERSON PARK AVENUE</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>WILLIAM GREENBORN</b>				<b>January 6 1956</b>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>MALE</b>	<b>WHITE</b>	<b>MARRIED</b>	<b>January 4, 1894</b>	<b>62</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>Pump Man</b>		<b>Beth. Steel Co.</b>		<b>Baltimore, Maryland</b>		<b>U.S.A.</b>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Gustav Greenborn</b>				<b>Unknown</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)</b>		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<b>Yes</b>		<b>WW-1</b>		<b>212-05-2750</b>			
				<b>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>420.1 IMMEDIATE CAUSE (A)</b>						<b>CORONARY OCCLUSION</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>						<b>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</b>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO</b>						<b>HYPERTENSIVE CARDIO-VASCULAR DISEASE</b>	
<b>(C)</b>						<b>UNKNOWN</b>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>						<b>UNKNOWN</b>	
<b>CONGESTIVE HEART FAILURE</b>						<b>UNKNOWN</b>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that</b> <b>VA</b> <b>Dec. 29, 1955</b> <b>to Jan. 6, 1956</b> <b>that I attended the deceased from</b> <b>2:35 PM</b> <b>and that death occurred at</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>		<b>DATE SIGNED</b>	
<b>WILLIAM E. HALL</b>				<b>VAH, Fort Howard, Maryland</b>		<b>1-7-56</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<b>Burial</b>		<b>Jan. 10, 1956</b>		<b>Baltimore National Cemetery</b>		<b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS</b>			
<b>DATE</b>				<b>ULLRICH FUNERAL HOME</b>			
<b>1-10-1956</b>				<b>4210 Belair Rd., Baltimore, Md.</b>			

(14)

BUREAU V. S.

JAN 11 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** No. *34*

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>Md.</b>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Md.</b>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Spawover Point</b>		STREET ADDRESS (If rural, give location) <b>3715 Towanda Ave</b>	
3. NAME OF DECEASED: (Type or Print)		4. DATE OF DEATH	
(First) <b>DAVID</b> (Middle) <b>MONIS</b> (Last) <b>GREENFIELD</b>		(Month) <b>1</b> (Day) <b>13</b> (Year) <b>1956</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>married</b>	8. DATE OF BIRTH: <b>Dec 18, 1904</b>
9. AGE last birthday: <b>51</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Steel Company</b>	
11. BIRTHPLACE (State or foreign country): <b>Baltimore, Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME: <b>416 Sol Greenfield</b>		14. MOTHER'S MAIDEN NAME: <b>Pauline Jones</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <b>William Greenfield - 2240 Linden Ave</b>	
17. INFORMANT & ADDRESS:			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
422.1 Immediate cause (a) <b>ARTERIOSCLEROTIC CARDIO- VASCULAR DISEASE</b>		
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)		
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE <b>Paul F. Merin</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-14-56</b>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		M. D. ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF <b>Jan 15/56</b>	NAME OF CEMETERY OR CREMATORY <b>Chesapeake Ameno</b>
LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>	24. FUNERAL DIRECTOR <b>Joe Barber &amp; Son</b>	
DATE REC'D BY LOCAL REGISTRAR'S SIGNATURE <b>Jan 15 1956</b>		ADDRESS <b>1124-26 W. North Ave</b>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 18 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00268

281

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Fort Howard</u>		<u>34 Days</u>		TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>2419 Arunah Avenue</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>BOOKERT W. GRIER</u>				<u>January 5 1956</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>August 4, 1918</u>	<u>37</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Railroad</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Waynesboro, S. Carolina</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U. S. A.</u>	
<b>13. FATHER'S NAME</b> <u>Clinton Grier</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Sarah Lightner</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>Yes</u> <u>WW II</u>		<b>16. SOCIAL SECURITY NO.</b> <u>249-05-2181</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>2 YEARS</b>	
<u>456X</u> IMMEDIATE CAUSE (A) <u>DISEMINATED LUPUS ERYTHEMATOSIS</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO							
STATING UNDERLYING CAUSE LAST. (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
		M. <input type="checkbox"/>					
<b>22. I hereby certify that I attended the deceased from <u>Dec. 2</u>, 19<u>55</u>, to <u>Jan. 5</u>, 19<u>56</u>, and that death occurred at <u>4:10 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Donald D. Mark</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. VAH, FORT HOWARD, MARYLAND</u>		<b>DATE SIGNED</b> <u>1-6-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>1-10-1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Baltimore National Cem.</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Baltimore, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Dawson L. Fisher</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Joseph L. Russ</u>		<b>ADDRESS</b> <u>2222 W. North Ave., Balto. Md.</u>	
<b>DATE</b> <u>Jan 6 1956</u>							



# CERTIFICATE OF DEATH

Form No. 10

1. Name of deceased (Print or write full name)

2. Sex (Male or Female)

3. Date of birth (Month, Day, Year)

4. Place of birth (City, State, Country)

5. Usual residence (Street, City, State, Country)

6. Date of death (Month, Day, Year)

7. Time of death (Hour, Minute)

8. Cause of death (Immediate cause)

9. Cause of death (Underlying cause)

10. Cause of death (Manner of death)

11. Signature of physician (Print name and sign)

12. Signature of registrar (Print name and sign)

13. Signature of informant (Print name and sign)

14. Signature of witness (Print name and sign)

15. Signature of witness (Print name and sign)

16. Signature of witness (Print name and sign)

17. Signature of witness (Print name and sign)

18. Signature of witness (Print name and sign)

19. Signature of witness (Print name and sign)

20. Signature of witness (Print name and sign)

21. Signature of witness (Print name and sign)

22. Signature of witness (Print name and sign)

23. Signature of witness (Print name and sign)

24. Signature of witness (Print name and sign)

25. Signature of witness (Print name and sign)

26. Signature of witness (Print name and sign)

27. Signature of witness (Print name and sign)

28. Signature of witness (Print name and sign)

29. Signature of witness (Print name and sign)

30. Signature of witness (Print name and sign)

31. Signature of witness (Print name and sign)

32. Signature of witness (Print name and sign)

33. Signature of witness (Print name and sign)

34. Signature of witness (Print name and sign)

35. Signature of witness (Print name and sign)

36. Signature of witness (Print name and sign)

37. Signature of witness (Print name and sign)

38. Signature of witness (Print name and sign)

39. Signature of witness (Print name and sign)

40. Signature of witness (Print name and sign)

41. Signature of witness (Print name and sign)

42. Signature of witness (Print name and sign)

43. Signature of witness (Print name and sign)

44. Signature of witness (Print name and sign)

45. Signature of witness (Print name and sign)

46. Signature of witness (Print name and sign)

47. Signature of witness (Print name and sign)

48. Signature of witness (Print name and sign)

49. Signature of witness (Print name and sign)

50. Signature of witness (Print name and sign)

51. Signature of witness (Print name and sign)

52. Signature of witness (Print name and sign)

53. Signature of witness (Print name and sign)

54. Signature of witness (Print name and sign)

55. Signature of witness (Print name and sign)

56. Signature of witness (Print name and sign)

57. Signature of witness (Print name and sign)

58. Signature of witness (Print name and sign)

59. Signature of witness (Print name and sign)

BUREAU V. S.

JAN 9 1956

RECEIVED

1234567890



282

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>White Marsh</u>		<u>Life</u>		TOWN <u>White Marsh</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>White Marsh, Md.</u>				STREET ADDRESS (If rural give location) <u>White Marsh, Md.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Anne</u>		(Middle) <u>Louise</u>		(Last) <u>Grimm</u>		(Month) (Day) (Year)	
						<u>Jan. 9, 1956</u>	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>July 13, 1945</u>	<u>10</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>None</u>					<u>White Marsh, Md.</u>		<u>U. S. A.</u>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Francis O. Grimm</u>				<u>Sarah E. Cogle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Francis O. Grimm White Marsh, Md.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Postinfectious Encephalopathy</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Probably Pertussis</u>				<u>3 yrs</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 1956</u> , to <u>Jan 9, 1956</u> , that I last saw the deceased alive on <u>Jan 9, 1956</u> , and that death occurred at <u>10 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Dr. Walter H. Smith</u> M.D. <u>Baltimore Md</u>				DATE SIGNED <u>1/11/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>Burial</u>		<u>1-12-1956</u>		<u>Morgland Memorial Park</u>		<u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
		<u>Dr. Walter H. Smith</u>		<u>Lashan Funeral Home - 7401 Belair Rd.</u>			

INSTRUCTIONS

1 TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

BUREAU V. S.

JAN 16 1952

RECEIVED

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15

00550

INSTRUCTIONS

1. This certificate is to be filled out by the physician or other qualified person who attended the deceased during his last illness. It should be filled out as soon as possible after death, and before the body is buried or cremated. It is a legal document and its contents are subject to the laws of the State of Maryland. It is the duty of the physician or other qualified person to fill out this certificate truthfully and accurately. It is the duty of the State Department of Health to receive and file this certificate, and to issue a death certificate to the family of the deceased. The death certificate is a legal document which is required for the burial or cremation of the deceased. It is also a record of the death of the deceased, and is used for statistical purposes. The death certificate is issued by the State Department of Health, and is valid throughout the State of Maryland. It is the duty of the family of the deceased to obtain a death certificate from the State Department of Health, and to use it for the burial or cremation of the deceased. The death certificate is a legal document, and its contents are subject to the laws of the State of Maryland. It is the duty of the physician or other qualified person to fill out this certificate truthfully and accurately. It is the duty of the State Department of Health to receive and file this certificate, and to issue a death certificate to the family of the deceased. The death certificate is a legal document which is required for the burial or cremation of the deceased. It is also a record of the death of the deceased, and is used for statistical purposes. The death certificate is issued by the State Department of Health, and is valid throughout the State of Maryland. It is the duty of the family of the deceased to obtain a death certificate from the State Department of Health, and to use it for the burial or cremation of the deceased.

1  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

283

## CERTIFICATE OF DEATH

00270

Reg. Dist. No. 31

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Woodlawn</b>	LENGTH OF STAY (in this place) <b>4 yrs</b>	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Woodlawn</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1924 Gwynn Oak Ave</b>		STREET ADDRESS (If rural give location) <b>1924 Gwynn Oak Ave</b>	
3. NAME OF DECEASED (Type or Print) <b>Anna E. Grimmer</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 23 1956</b>	
5. SEX <b>F.</b>	6. COLOR OR RACE <b>W.</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Oct. 10, 1903</b>
9. AGE last birthday <b>52</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Saleslady</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hutzlers</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Andrew Kurtz</b>		14. MOTHER'S MAIDEN NAME <b>Emma</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-03-6134</b>	
17. INFORMANT & ADDRESS <b>Mr. Raymond Grimmer, 1924 Gwynn Oak Ave</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <b>420.1 IMMEDIATE CAUSE (A) Coronary Occlusion -</b>		<b>1 day -</b>	
ANTECEDENT CAUSE(S) DUE TO <b>Acute Degenerative Heart Failure -</b>		<b>2 mos -</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. <b>Chronic Degenerative Heart disease</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>post - Rheumatic fever</b>		<b>45 years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Jan 23, 1956</b> , to <b>Jan 23, 1956</b> , that I last saw the deceased alive on <b>Jan 23, 1956</b> , and that death occurred at <b>11:30 P.M.</b> from the causes and on the date stated above.			
SIGNATURE <b>Thomas E. Wheeler</b>		ADDRESS (Street, city, town, state) <b>3601 Clifmark Rd - Baltimore - Md.</b>	
DATE SIGNED <b>1/23/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jan. 26/56</b>	
NAME OF CEMETERY OR CREMATORY <b>Loudon Park</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
24. REG'D BY REGISTRAR <b>Dr. Thos. E. Martin</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>Harry H. Witke</b>	
ADDRESS <b>4101 Edmondson Ave</b>			

# CERTIFICATE OF DEATH

230

DATE OF DEATH

DEATH OCCURRED AT HOME OR IN INSTITUTION

PLACE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

SEX

AGE

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

SEX

AGE

CAUSE OF DEATH

PLACE OF DEATH

SEX

CAUSE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

BUREAU V. S.

JAN 26 1956

RECEIVED

284

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Towson</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1642 Yakona Road</b>				STREET ADDRESS (If rural give location) <b>1642 Yakona Road</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>CATHERINE ELIZABETH GROOM</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>January 25, 1956</b>			
5. SEX: <b>Female</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>October 7, 1873</b>	9. AGE last birthday <b>82</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Own Home</b>		11. BIRTHPLACE (State or foreign country): <b>New Jersey</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME: <b>George W. Wilson</b>				14. MOTHER'S MAIDEN NAME: <b>Christine Sellars</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY No. <b>None</b>		17. INFORMANT & ADDRESS: <b>Harry Groom, 1642 Yakona Rd., Towson, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Carcinoma of common bile duct</b>						3 mos.	
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B)							
DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY M.		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1/15</u> , 19 <u>56</u> , to <u>1/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/25</u> , 19 <u>56</u> , and that death occurred at <u>10 A</u> M, from the causes and on the date stated above. SIGNATURE <u>Harry Groom</u> ADDRESS <u>8513 York Road Bld</u> DATE SIGNED <u>1/26/56</u> M.D.							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jan. 28, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Prospect Hill Cemetery</b>		LOCATION (City, town, or county) (State) <b>Towson, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 28, 1956</u>		REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>		24. FUNERAL DIRECTOR ADDRESS <b>John Burns' Sons, Towson, Maryland</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 30 1956

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00272

285

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard, Md.</u>		<u>49 Days</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>827 Washington Boulevard</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) <u>GEORGE</u>		(Middle) <u>H.</u>		(Last) <u>GROSS</u>		<u>January 3, 1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>April 27, 1892</u>		9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR (Months) (Days) IF UNDER 24 HRS. (Hours) (Min.)	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Grain</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>George H. Gross</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Slicker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT & ADDRESS <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>			
(If Yes, give year or dates of service) <u>WW I</u>							
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
1 I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
442X IMMEDIATE CAUSE (A) <u>CHRONIC ARTERIOSCLEROTIC NEPHRITIS</u>						3 YEARS	
ANTECEDENT CAUSE(S) DUE TO <u>HYPERTENSION</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) _____							
(C) _____							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>CONGESTIVE HEART FAILURE</u>						3 MONTHS	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 15</u> , 19 <u>55</u> , to <u>Jan. 3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 15</u> , 19 <u>55</u> , and that death occurred at <u>1:40 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald D. Mark, M.D.</u>				ADDRESS (Street, city, town, state) <u>VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>1-4-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/6/56</u>		NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>1/5/56</u>		REGISTRAR'S SIGNATURE <u>Wm. Cook-Blight, Inc.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook-Blight, Inc. 6009 Harford Rd. Balto. Md.</u>			
DATE							

Dawson &amp; L. Lockers

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-BATTELLE 10

Form No. 10

1. FULL NAME (LAST, FIRST, MIDDLE)

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. PLACE OF DEATH

9. CAUSE OF DEATH

10. MANNER OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF FUNERAL HOME

15. SIGNATURE OF BURIAL PLACE

16. SIGNATURE OF INTERVIEWER

17. SIGNATURE OF CORoner

18. SIGNATURE OF JURY

19. SIGNATURE OF COURT

20. SIGNATURE OF STATE

BUREAU V. S.

JAN 6 1956

RECEIVED

MASSACHUSETTS

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00273

286

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Balto.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cockeysville</u>		<u>Life</u>		TOWN <u>Cockeysville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>Bosley Ave</u>							
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Rebecca</u> (Middle) <u>Virginia</u> (Last) <u>Haines</u>				(Month) <u>1</u> (Day) <u>31</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 Year		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Dec. 13, 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>				<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>William Hedrick</u>				<u>Mary Funk</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>no</u>				<u>Mrs Fred Smith Bosley Ave, Cockeysville</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.2 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Myocardial Regeneration</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/30/1955</u> to <u>11/30/1956</u> , that I last saw the deceased alive on <u>11/30/1956</u> , and that death occurred at <u>12:10</u> M. from the causes and on the date stated above.							
SIGNATURE		M.D.		ADDRESS (Street, city, town, state)		DATE SIGNED	
<u>M. K. Quinn</u>				<u>TIMONIUM</u>		<u>1/31/57</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<u>BURIAL</u>		<u>2-2-56</u>		<u>Poplar Methodist</u>		<u>Cockeysville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>2 Feb 1956</u>		<u>Quinn Quinn</u>		<u>L Scott Brooks</u>		<u>Sharps Md.</u>	



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00274

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL or end give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Overlea</u>		<u>7 Months</u>		TOWN <u>Overlea</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>14 Madeline Ave.</u>				<u>14 Madeline Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Flora</u> (Middle) <u>Gay</u> (Last) <u>Hamric</u>				(Month) <u>January</u> (Day) <u>10</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Nov. 4, 1873</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>At Home</u>		<u>West Virginia</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Isaac Boggs</u>				<u>Mary Garey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Henry D. Parks 14 Madeline Ave.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>4 hours.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>						<u>many years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21a. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 19 55</u> , to <u>Jan 10 19 56</u> , that I last saw the deceased alive on <u>Jan 10 19 56</u> , and that death occurred at <u>2:08 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Max R. English</u> M.D. <u>5713 Belair Rd</u>				ADDRESS (Street, city, town, state) <u>Baltimore 1-10-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>1-10-1956</u>		<u>Slamps</u>		<u>Sugar Grove, Va.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>Jan. 11, 1956</u>		<u>Mrs. L. L. Reifeneider</u>		<u>Lawson Funeral Home</u>		<u>7401 Belair Rd.</u>	



RECEIVED

JAN 11 1956

BUREAU V. S.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

1. NAME OF DECEASED <i>John A. Smith</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>Jan 10 1956</i>		5. TIME OF DEATH <i>10:30 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. OCCUPATION <i>Retired</i>		8. MARITAL STATUS <i>Married</i>		9. PLACE OF BIRTH <i>MD</i>	
10. CAUSE OF DEATH <i>Heart Disease</i>		11. MANNER OF DEATH <i>Natural</i>		12. SIGNATURE OF PHYSICIAN <i>Dr. J. B. Jones</i>	
13. SIGNATURE OF DECEASED <i>John A. Smith</i>		14. SIGNATURE OF WITNESSES <i>Mr. &amp; Mrs. J. A. Smith</i>		15. SIGNATURE OF REGISTRAR <i>John D. Doe</i>	

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD. IT IS NOT VALID FOR THE PURPOSES OF THE FEDERAL GOVERNMENT OR ANY OTHER AGENCY.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00275  
**CERTIFICATE OF DEATH** Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Baltimore</i>	MARYLAND	STATE <i>Id</i>	COUNTY <i>Prince Georges Co</i>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <i>52 Columbia 28</i>	LENGTH OF STAY (in this place) <i>Since July 14, 1953</i>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Washington 19</i>	<i>164-2</i>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>14 Spring Grove Hospital</i>		STREET ADDRESS (If rural give location) <i>9, Delano Drive</i>	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>HAZEL C HARDY</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>1. 21 1956</i>	
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Married</i>	8. DATE OF BIRTH: <i>1. 10. 1902</i>
9. AGE last birthday <i>54</i> yrs.		10. BIRTHPLACE (State or foreign country): <i>USA</i>	11. CITIZEN OF WHAT COUNTRY? <i>USA</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
13. FATHER'S NAME: <i>Charles A Gray</i>		14. MOTHER'S MAIDEN NAME: <i>Mary F Willis</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT & ADDRESS:	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
331X IMMEDIATE CAUSE (A) <i>Cerebral Haemorrhage</i>		
ANTECEDENT CAUSE (B) DUE TO		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
260X (C) DUE TO		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Diabetes</i>		

19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
----------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------	--------------------------------------------------------------

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
-------------------------------------------------	--------------------------------------------------------------------------------------------------------	----------------------------

22. I hereby certify that I attended the deceased from *7.14*, 1953, to *1.21*, 1956, that I last saw the deceased alive on *1.21*, 1956, and that death occurred at *12.10 p M.*, from the causes and on the date stated above.

SIGNATURE <i>Rena Becker</i>	ADDRESS <i>M. D. Spring Grove Hospital</i>	DATE SIGNED <i>1/21/56</i>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>	DATE THEREOF <i>Jan. 24-56</i>	NAME OF CEMETERY OR CREMATORY <i>Cedar Hill</i>
LOCATION (City, town, or county) (State) <i>Southland Md</i>	24. FUNERAL DIRECTOR <i>Demmons Bros. 1661-1400 Hwy Rd SE</i>	ADDRESS <i>Washington DC</i>
DATE REC'D BY LOCAL REGISTRAR <i>Jan. 21-56</i>	REGISTRAR'S SIGNATURE <i>T. E. Harry</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JAN 24 1936  
BUREAU V. 3

Order of Remittance

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Value of Property

VIN

for F. W. W.

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March 10 1935

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by

March 1 21

289

## CERTIFICATE OF DEATH

Reg. Dist. No.

32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Harrison</u>		<u>45 yrs.</u>		TOWN <u>Harrison</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Robert Barker Harrison Sr.</u>				OF DEATH: <u>JAN. 17 1956</u>			
5. SEX: <u>m</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>Jan 14 1878</u>	
				9. AGE last birthday: <u>77</u> yrs.		IF UNDER 1 YEAR: Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Insurance</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Insurance</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Thomas B Harrison</u>				14. MOTHER'S MAIDEN NAME: <u>Mary Williams</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>no</u>		16. SOCIAL SECURITY NO.: <u>220-30-4966</u>		17. INFORMANT & ADDRESS: <u>Mrs Robert B. Harrison Sr.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>420.0</u> <u>Arteriosclerotic Heart Disease</u>						<u>5 yrs.</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1957</u> , to <u>17 Jan., 1956</u> , that I last saw the deceased alive on <u>17 Jan., 1956</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Paul H. Royce M.D.</u>		<u>Pikesville 8 Ind</u>		<u>17 Jan 56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 19, 1956</u>		<u>St. Thomas Cemetery</u>		<u>Harrison, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Jan. 18, 1956</u>		<u>Arrothy A. Newell</u>		<u>Frank H. Newell</u>		<u>Pikesville</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. 3

JAN 27 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

00277

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 44

Item 7, Film G191 1-16-56 et

1. PLACE OF DEATH - COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Baltimore</u> COUNTY <u>Md.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Spawns Point, Md.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>7352 Hughes Ave.</u>	
TOWN <u>Spawns Pt.</u>		STREET ADDRESS (If rural, give location) <u>Hosp.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spawns Pt. Hosp.</u>			
3. NAME OF DECEASED (Type or Print) (First) <u>Glenn R. Heffner</u> (Middle) <u>Heffner</u> (Last) <u>Heffner</u>		4. DATE OF DEATH (Month) <u>1</u> - (Day) <u>9</u> (Year) <u>1946</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 29, 1914</u>
9. AGE last birthday <u>32</u> yrs.		10. If under 1 year: Months <u>8</u> Days <u>18</u> Hours <u>18</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Int. Sec. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>			
13. FATHER'S NAME <u>William T. Heffner</u>		14. MOTHER'S MAIDEN NAME <u>Lillian A. Warfel</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>Elhel B. Heffner, Sp. Pt. Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## Immediate cause

Crushing Injury to Left Pelvis 13th

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last

Dislocation of SymphysisInternal Injuries to Lower Left Abdomen

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		PLACE OF INJURY (Home, farm, factory, street, office, hotel, etc.) <u>Spawns Pt. - 66" Muri</u>		(CITY OR TOWN) <u>Spawns Pt.</u> (COUNTY) <u>Baltimore</u> (STATE) <u>Md.</u>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1-9-56 10:00 a.m.</u>		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		HOW DID INJURY OCCUR <u>Struck &amp; Heavy Blow in Lower Left Abdomen</u>	

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☐ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐.

## SIGNATURE

(Degree or title)

## ADDRESS

## DATE SIGNED

23. BURIAL, CREMATION (BY) (Specify) <u>Burial</u>		DATE THEREOF <u>1-13-56</u>		NAME OF CEMETERY OR CREMATORY <u>Union Church</u>		LOCATION (City, town, or county) (State) <u>Huntingdon, Pa.</u>	
DATE REC'D BY LOCAL REG. <u>1/14/56</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>W. M. Cook, Inc.</u>		ADDRESS <u>1211 St. Paul St. Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

6400 Mornington Rd.

Dear Sirs.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00278

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>X Ruston</u>	LENGTH OF STAY (in this place) <u>2 wks</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Balto</u>	TOWN <u>3401.4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Nursing Home Sorensen</u>	STREET ADDRESS (If rural give location) <u>5601 Winner Ave</u>		
3. NAME OF DECEASED (Type or Print) <u>Ernest R. Helmrich</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>1-20 1956</u>	
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>D.</u>	8. DATE OF BIRTH <u>Apr 24 1899</u>
		9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR (Month) (Day) (Year) <u>8 27</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Night Watchman Royal Crown Bottling</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Balto</u>	12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>
13. FATHER'S NAME <u>Henry Helmrich</u>		14. MOTHER'S MAIDEN NAME <u>Amelia Runk</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-10-4219</u>	
		17. INFORMANT & ADDRESS <u>Thomas R. Waeche 5601 Winner Ave</u>	
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>410X Hypertrophy myocardium c failure</u>		<u>left ventricular</u> <u>1 year</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Valvular disease chronic cardiac mitral</u>		<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cardiac Asthma severe</u>		<u>2 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Myocarditis chronic</u>		<u>5 years</u>	
19a. DATE OF OPERATION <u>no operation</u>	19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>	20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>no injury</u>	21b. PLACE (Home, farm, factory, OF INJURY, street, office bldg., etc.) <u>no injury</u>	21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>no injury</u>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>no injury</u>	21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>no injury</u>	
22. I hereby certify that I attended the deceased from <u>Jan 5</u> , 19 <u>56</u> , to <u>Jan 20</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 19</u> , 19 <u>56</u> , and that death occurred at <u>10.45</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Jamus Graham Martin</u>		ADDRESS (Street, city, town, state) <u>515 Cathedral St Baltimore Md</u>	
DATE <u>Jan 24, 1956</u>		DATE SIGNED <u>I-21-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>1-23-56</u>	NAME OF CEMETERY OR CREMATORY <u>Western Cemetery</u>	LOCATION (City, town, or county) (State) <u>Balto Md</u>
24. REC'D BY REGISTRAR <u>Jan. 24, 1956</u>	REGISTRAR'S SIGNATURE <u>Mabel Guy</u>	25. FUNERAL DIRECTOR'S SIGNATURE <u>Edwing Byers</u>	ADDRESS <u>5005 Pk. Hyattsville Balto 15, Md.</u>

# CERTIFICATE OF DEATH

Form 100-100

1. DEATH CERTIFICATE (NUMBER OF DEATHS)

2. PLACE OF DEATH

3. DATE OF DEATH  
 4. TIME OF DEATH  
 5. PLACE OF DEATH  
 6. NAME OF DECEASED  
 7. SEX  
 8. AGE  
 9. RACE  
 10. OCCUPATION  
 11. MARITAL STATUS  
 12. CAUSE OF DEATH  
 13. MANNER OF DEATH  
 14. SIGNATURE OF PHYSICIAN  
 15. SIGNATURE OF REGISTRAR  
 16. DATE OF REGISTRATION

17. PLACE OF DEATH  
 18. NAME OF DECEASED  
 19. SEX  
 20. AGE  
 21. RACE  
 22. OCCUPATION  
 23. MARITAL STATUS  
 24. CAUSE OF DEATH  
 25. MANNER OF DEATH  
 26. SIGNATURE OF PHYSICIAN  
 27. SIGNATURE OF REGISTRAR  
 28. DATE OF REGISTRATION

29. PLACE OF DEATH  
 30. NAME OF DECEASED  
 31. SEX  
 32. AGE  
 33. RACE  
 34. OCCUPATION  
 35. MARITAL STATUS  
 36. CAUSE OF DEATH  
 37. MANNER OF DEATH  
 38. SIGNATURE OF PHYSICIAN  
 39. SIGNATURE OF REGISTRAR  
 40. DATE OF REGISTRATION

41. PLACE OF DEATH  
 42. NAME OF DECEASED  
 43. SEX  
 44. AGE  
 45. RACE  
 46. OCCUPATION  
 47. MARITAL STATUS  
 48. CAUSE OF DEATH  
 49. MANNER OF DEATH  
 50. SIGNATURE OF PHYSICIAN  
 51. SIGNATURE OF REGISTRAR  
 52. DATE OF REGISTRATION

53. PLACE OF DEATH  
 54. NAME OF DECEASED  
 55. SEX  
 56. AGE  
 57. RACE  
 58. OCCUPATION  
 59. MARITAL STATUS  
 60. CAUSE OF DEATH  
 61. MANNER OF DEATH  
 62. SIGNATURE OF PHYSICIAN  
 63. SIGNATURE OF REGISTRAR  
 64. DATE OF REGISTRATION

65. PLACE OF DEATH  
 66. NAME OF DECEASED  
 67. SEX  
 68. AGE  
 69. RACE  
 70. OCCUPATION  
 71. MARITAL STATUS  
 72. CAUSE OF DEATH  
 73. MANNER OF DEATH  
 74. SIGNATURE OF PHYSICIAN  
 75. SIGNATURE OF REGISTRAR  
 76. DATE OF REGISTRATION

77. PLACE OF DEATH  
 78. NAME OF DECEASED  
 79. SEX  
 80. AGE  
 81. RACE  
 82. OCCUPATION  
 83. MARITAL STATUS  
 84. CAUSE OF DEATH  
 85. MANNER OF DEATH  
 86. SIGNATURE OF PHYSICIAN  
 87. SIGNATURE OF REGISTRAR  
 88. DATE OF REGISTRATION

89. PLACE OF DEATH  
 90. NAME OF DECEASED  
 91. SEX  
 92. AGE  
 93. RACE  
 94. OCCUPATION  
 95. MARITAL STATUS  
 96. CAUSE OF DEATH  
 97. MANNER OF DEATH  
 98. SIGNATURE OF PHYSICIAN  
 99. SIGNATURE OF REGISTRAR  
 100. DATE OF REGISTRATION

101. PLACE OF DEATH  
 102. NAME OF DECEASED  
 103. SEX  
 104. AGE  
 105. RACE  
 106. OCCUPATION  
 107. MARITAL STATUS  
 108. CAUSE OF DEATH  
 109. MANNER OF DEATH  
 110. SIGNATURE OF PHYSICIAN  
 111. SIGNATURE OF REGISTRAR  
 112. DATE OF REGISTRATION

113. PLACE OF DEATH  
 114. NAME OF DECEASED  
 115. SEX  
 116. AGE  
 117. RACE  
 118. OCCUPATION  
 119. MARITAL STATUS  
 120. CAUSE OF DEATH  
 121. MANNER OF DEATH  
 122. SIGNATURE OF PHYSICIAN  
 123. SIGNATURE OF REGISTRAR  
 124. DATE OF REGISTRATION

125. PLACE OF DEATH  
 126. NAME OF DECEASED  
 127. SEX  
 128. AGE  
 129. RACE  
 130. OCCUPATION  
 131. MARITAL STATUS  
 132. CAUSE OF DEATH  
 133. MANNER OF DEATH  
 134. SIGNATURE OF PHYSICIAN  
 135. SIGNATURE OF REGISTRAR  
 136. DATE OF REGISTRATION

137. PLACE OF DEATH  
 138. NAME OF DECEASED  
 139. SEX  
 140. AGE  
 141. RACE  
 142. OCCUPATION  
 143. MARITAL STATUS  
 144. CAUSE OF DEATH  
 145. MANNER OF DEATH  
 146. SIGNATURE OF PHYSICIAN  
 147. SIGNATURE OF REGISTRAR  
 148. DATE OF REGISTRATION

149. PLACE OF DEATH  
 150. NAME OF DECEASED  
 151. SEX  
 152. AGE  
 153. RACE  
 154. OCCUPATION  
 155. MARITAL STATUS  
 156. CAUSE OF DEATH  
 157. MANNER OF DEATH  
 158. SIGNATURE OF PHYSICIAN  
 159. SIGNATURE OF REGISTRAR  
 160. DATE OF REGISTRATION

161. PLACE OF DEATH  
 162. NAME OF DECEASED  
 163. SEX  
 164. AGE  
 165. RACE  
 166. OCCUPATION  
 167. MARITAL STATUS  
 168. CAUSE OF DEATH  
 169. MANNER OF DEATH  
 170. SIGNATURE OF PHYSICIAN  
 171. SIGNATURE OF REGISTRAR  
 172. DATE OF REGISTRATION

173. PLACE OF DEATH  
 174. NAME OF DECEASED  
 175. SEX  
 176. AGE  
 177. RACE  
 178. OCCUPATION  
 179. MARITAL STATUS  
 180. CAUSE OF DEATH  
 181. MANNER OF DEATH  
 182. SIGNATURE OF PHYSICIAN  
 183. SIGNATURE OF REGISTRAR  
 184. DATE OF REGISTRATION

BUREAU V. S.

JAN 25 1956

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 JAN 25 1956  
 BUREAU V. S.

292

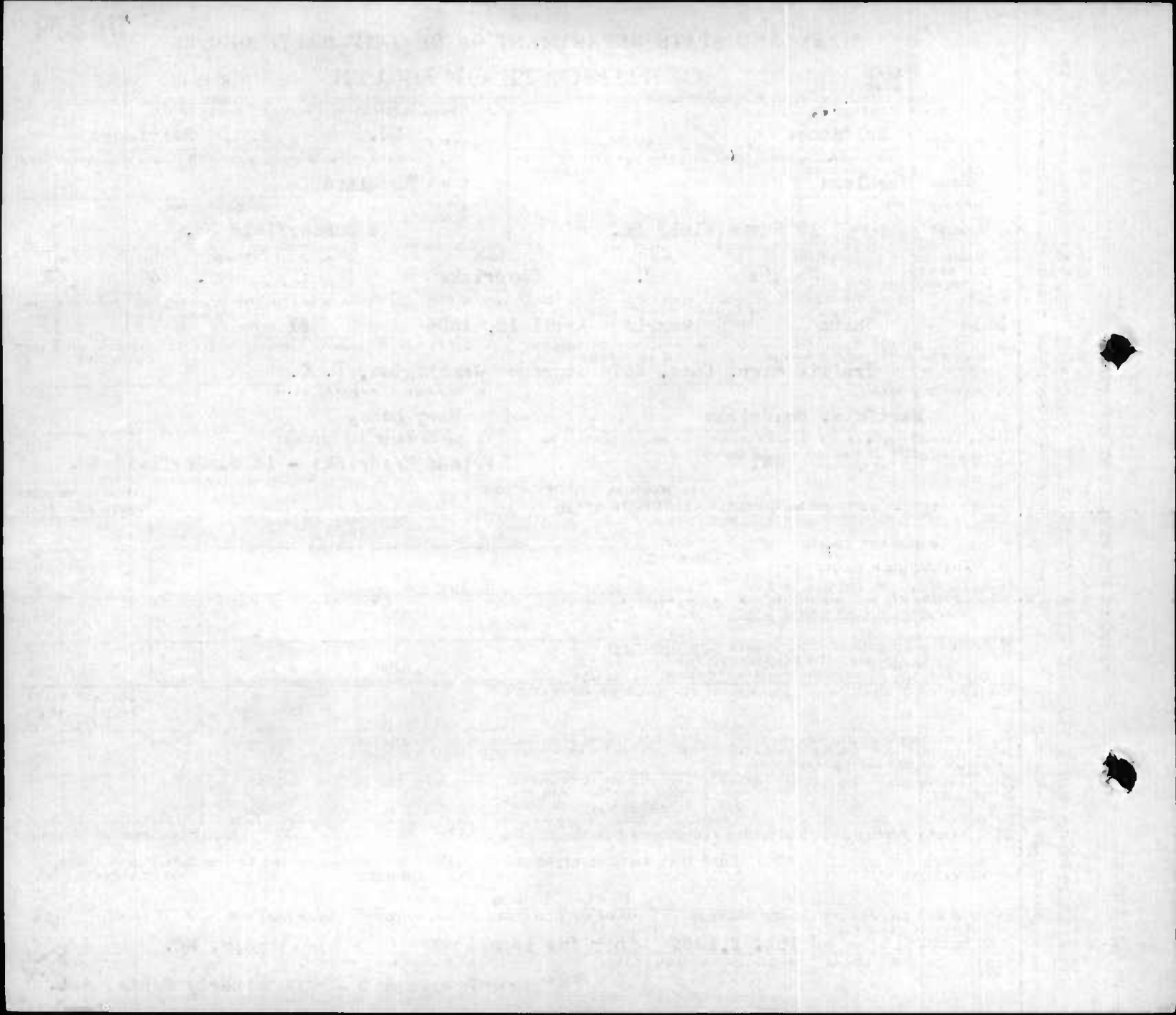
## CERTIFICATE OF DEATH

Reg. Dist. No. 31

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Woodlawn</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>18 Summerfield Rd.</b>				STREET ADDRESS (If rural give location) <b>18 Summerfield Rd.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Martin J. Hendricks</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>Jan. 30 1956</b>			
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>April 19, 1894</b>	9. AGE last birthday <b>61</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Traffic Mgr. Cons. Cold Storage</b>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <b>Washington, D. C.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Martin J. Hendricks</b>				14. MOTHER'S MAIDEN NAME: <b>Mary Leahy</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW1</b>		17. INFORMANT & ADDRESS: <b>Frieda Hendricks - 18 Summerfield Rd.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <b>153X</b>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <b>Chronic Myocarditis</b>						<b>2 weeks</b>	
(B) <b>Metastatic Hepatic Metastasis</b>						<b>4 mos</b>	
(C) <b>Carcinoma of Descending Colon</b>						<b>6 mos</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>C.P.L. Kidney with anemia</b>						<b>3 days</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Oct 15, 1942</b> to <b>Jan 30, 1956</b> that I last saw the deceased alive on <b>Jan 26, 1956</b> , and that death occurred at <b>10:45 A.M.</b> from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
				<b>Jan 31, 1956</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Entombment</b>		DATE THEREOF <b>Feb. 2, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>7-31-56</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>Ellsworth Armacost - 4600 Liberty Hgts. Ave. 7</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00280

293

## CERTIFICATE OF DEATH

Reg. Dist. No. 35

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
TOWN <u>Rural-Parkton 20 yrs.</u>				TOWN <u>Rural-Parkton.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Old York Rd.</u>				STREET ADDRESS (If rural give location) <u>Old York Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Rhoda</u> (Middle) <u>E.</u> (Last) <u>Hershner</u>				(Month) <u>Jan.</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Married</u>	<u>Sept. 9 1902</u>	<u>53</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Own home.</u>		<u>Railroad Pa. U.S.A.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Wm S. Brose.</u>				<u>Emma J. Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>				<u>Calvin M Hershner, Parkton Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
420.1 IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>coronary sclerosis</u>						<u>1 yr</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chr. interstitial Nephritis</u>						<u>10 yrs.</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Sept 1</u> , 19 <u>55</u> , to <u>Jan 6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 5</u> , 19 <u>56</u> , and that death occurred at <u>3:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Paul D. Chant</u>				ADDRESS (Street, city, town, state) <u>Shrewsbury Pa</u>		DATE SIGNED <u>1-8-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan 9 1956</u>		<u>Shrewsbury Lutheran</u>		<u>Shrewsbury, York Co, Pa.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>AN 12 1956</u>		<u>Mrs. Howard Marklin</u>		<u>Jacob Parkstein</u>		<u>New Freedom, Pa.</u>	



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BUREAU V. S.

JAN 12 1956

RECEIVED

[illegible]



00281

## MARYLAND STATE DEPARTMENT OF HEALTH

294

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. ....

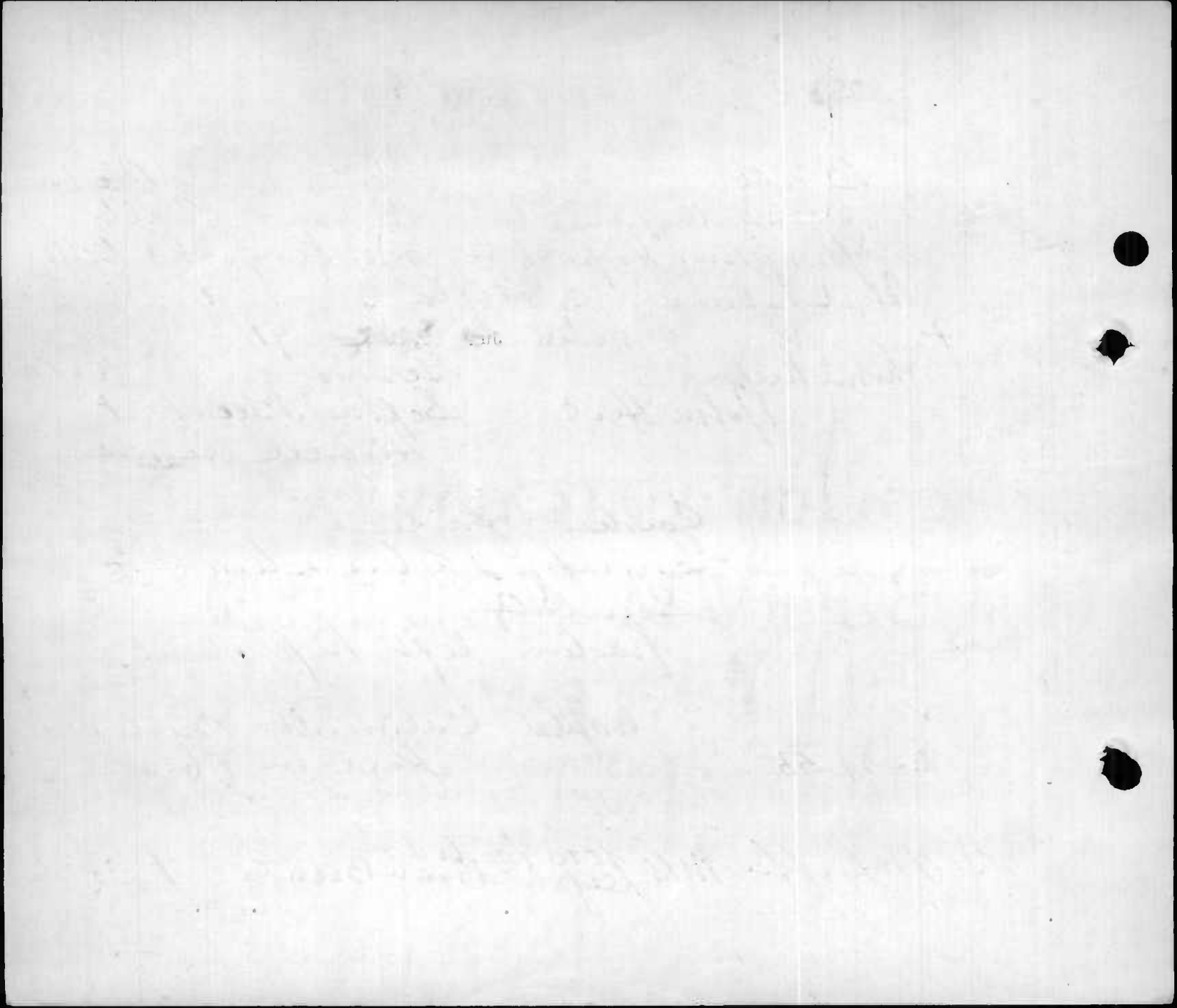
1. PLACE OF DEATH - COUNTY <u>Balto</u>		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural Balto</u>	
TOWN <u>9-9-53</u>		TOWN <u>1-7-56</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Springton Hosp</u>		STREET ADDRESS (If rural, give location) <u>3644 Langrich Rd Balto</u>	
3. NAME OF DECEASED (Type or Print) <u>Wilhelmina S Hilliard</u>		4. DATE OF DEATH (Month) <u>1</u> (Day) <u>7</u> (Year) <u>1956</u>	
5. SEX <u>7</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>widow</u>	8. DATE OF BIRTH <u>July 11, 1864</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, and if retired) <u>Home Keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>91</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
13. FATHER'S NAME <u>John Hill</u>		14. MOTHER'S MAIDEN NAME <u>Sophia Hempert</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>no</u>	
17. INFORMANT AND ADDRESS <u>Hospital Records</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
<p>9047</p> <p>Immediate cause (a) <u>Cardiac failure</u></p> <p>Antecedent cause(s) (b) <u>Generalized arteriosclerosis</u></p> <p>Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Senility</u></p>		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>fracture left hip + knee</u>		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Hospital</u>	(CITY OR TOWN) <u>Catonsville</u> (COUNTY) <u>Balto</u> (STATE) <u>Md</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Dec 27-53</u> m.	INJURY OCCURRED While at work <input type="checkbox"/> No while at work <input checked="" type="checkbox"/>	HOW DID INJURY OCCUR? <u>fell on floor</u>
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input type="checkbox"/> accident <input checked="" type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/> .		
SIGNATURE <u>Wm. H. Kieffer M.D.</u> (Degree or title)		DATE SIGNED <u>1-8-56</u>
23. BURIAL, CREMATION REMOVED (Specify) <u>Burial</u>	DATE THEREOF <u>1/11/56</u>	NAME OF CEMETERY OR CREMATOR <u>Western Cem.</u>
LOCATION (City, town, or county) <u>Balto., Md.</u>		(State) <u>Md.</u>
DATE REC'D BY LOCAL REG. <u>1/9/56</u>	REGISTRAR'S SIGNATURE <u>Wm. H. Kieffer</u>	24. FUNERAL DIRECTOR <u>Wm. J. Dickner &amp; Sons</u>
ADDRESS <u>Balto 17</u>		<u>Md.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



00282

## MARYLAND STATE DEPARTMENT OF HEALTH

Item 18 Film G192 2-8-56

295

CERTIFICATE OF DEATH  
FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>		STREET ADDRESS (If rural, give location) <u>76 Edgewater Apts - Balto. 21, Md.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>David</u>	(Middle) <u>Allen</u>	(Last) <u>Hornwood</u>
4. DATE OF DEATH	(Month) <u>1</u>	(Day) <u>23</u>	(Year) <u>1956</u>
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>single</u>	8. DATE OF BIRTH <u>9-30-38</u>
9. AGE last birthday <u>17</u> yrs.		10. AGE last birthday If under 1 year Months Days If under 24 hrs. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>photography</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Julius Hornwood</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Landau</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT AND ADDRESS <u>Records Spring Grove State Hospital</u>			

## 18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Congestive heart failure</u> Antecedent cause(s) (b) <u>due to undetermined cause</u> Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☐ homicide ☐ undetermined ☐

SIGNATURE

(Degree or title)

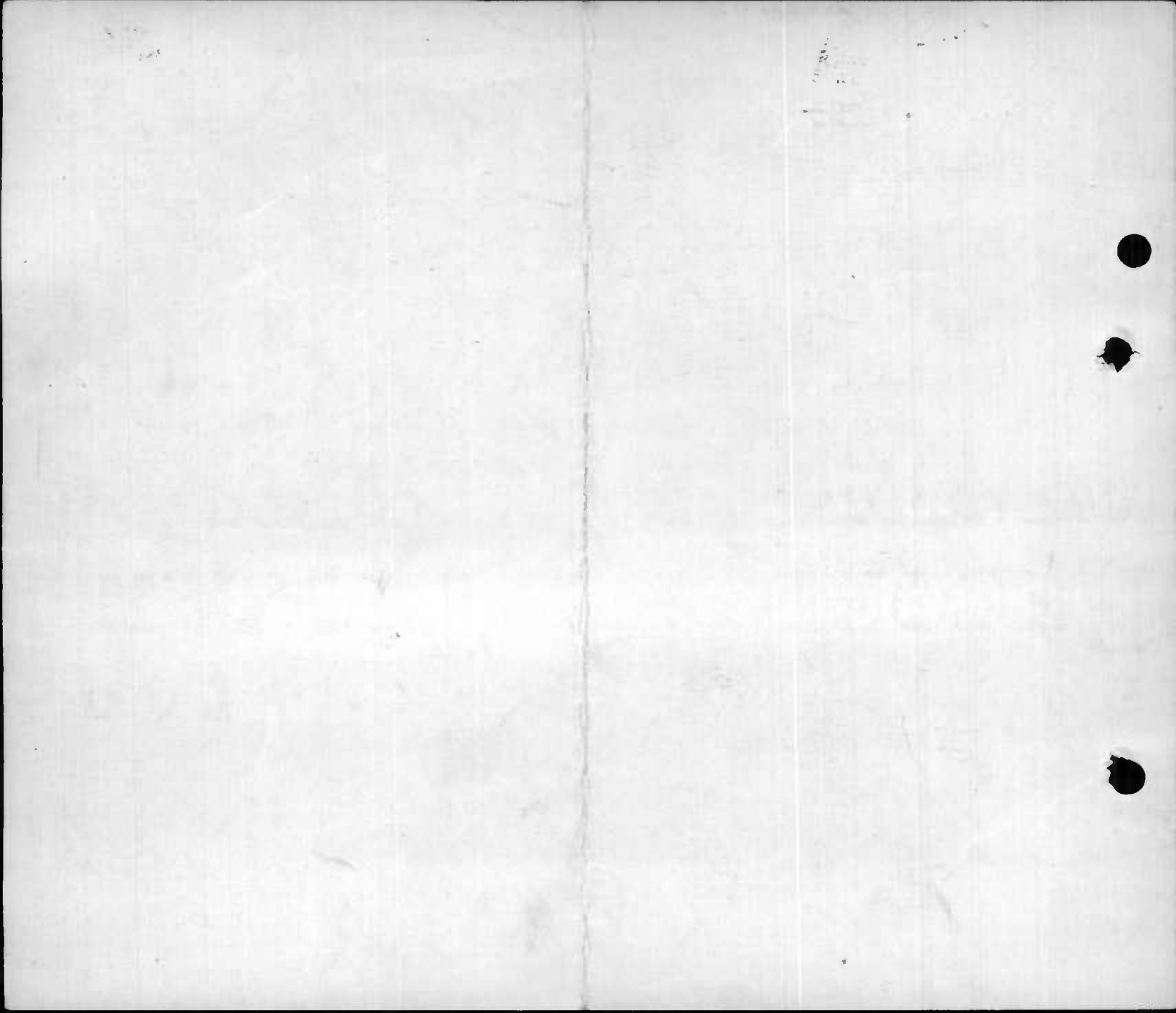
ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Removal</u>	<u>1/24/56</u>	<u>New Montefiore Cemetery</u>	<u>Pinelawn, New York</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/24/56</u>	<u>A. W. Hedrich &amp; Co.</u>	<u>Wm. Cook, Inc.</u>	<u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



296

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Balto.</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Towson</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>614 Overbrook Rd.</b>				STREET ADDRESS (If rural give location) <b>614 Overbrook Rd.</b>			
3. NAME OF DECEASED: (First) (Middle) (Last) <b>MARION S. HUBBARD</b>				4. DATE (Month) (Day) (Year) OF DEATH: <b>Jan. 27, 1956</b>			
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <b>widowed</b>	8. DATE OF BIRTH: <b>April 10, 1864</b>	9. AGE last birthday <b>91</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>Salesman (Rtd)</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Retail Shoes</b>		11. BIRTHPLACE (State or foreign country): <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>John Thomas Hubbard</b>				14. MOTHER'S MAIDEN NAME: <b>Georgiana Coffin</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <b>no</b>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service): <b>212-14-2520</b>		17. INFORMANT & ADDRESS: <b>Mrs. Elra M. Palmer - 614 Overbrook Rd.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Cardiac Decomp.</b>						<b>3-4 da.</b>	
ANTECEDENT CAUSE (S) (B) <b>Atherosclerotic CVD</b>						<b>?</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Pneumonia Arterial</b>						<b>3 yrs.</b>	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Nov 27, 1955</b> to <b>Jan 27, 1956</b> that I last saw the deceased alive on <b>Jan 20, 1956</b> , and that death occurred <b>all: 4PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Lawrence J. Humm</b>		M. D. <b>3711 2nd Rd</b>		DATE SIGNED <b>Balto 11/9/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/31/56</b>		NAME OF CEMETERY OR CREMATORY <b>Olivet Cem.</b>		LOCATION (City, town, or county) (State) <b>St. Michaels, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1-30-56</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>[Signature]</b>		ADDRESS <b>[Address]</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





00284

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

297

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
OR TOWN <u>Fort Howard</u>		<u>3 days</u>		OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 Veterans Administration Hospital</u>				<u>1219 Urban Way</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>WILLIAM C. HUMPHRESS</u>				<u>January 22 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>11/8/88</u>	<u>67 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Soldier</u>				<u>U. S. Army</u>		<u>Casey Creek, Kentucky</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Talbert Humphress</u>				<u>Martha Woolford</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes WW II</u>				<u>Unknown</u>		<u>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>331X Cerebrovascular Accident</u>							<u>UNKNOWN</u>
ANTECEDENT CAUSE (B) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
260X (C) DUE TO							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
<u>DIABETES MELLITUS</u>							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
						INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 19, 1956, to Jan 22, 1956, that he died on the deceased and that death occurred at 5:45 AM, from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<u>WILLIAM H. SLASMAN</u>				<u>Fort Howard, Md.</u>		<u>1/22/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1/25/56</u>		<u>Baltimore National Cemetery</u>		<u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1/23/56</u>		<u>A. W. Hedrich</u>		<u>Walter Dabrowski Funeral Home</u>		<u>1001-A Dundalk Ave., Balto 24, Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

00804

RECEIVED

201



298

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY <u>BALTO.</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>GARRISON</u>		LENGTH OF STAY (in this place) <u>27 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>GARRISON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>REISTERSTOWN Rd.</u>				STREET ADDRESS (If rural give location) <u>REISTERSTOWN Rd. (RURAL)</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>ROBERT LITTLE JAMES</u>				<u>1-3 1956</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		8. DATE OF BIRTH: <u>MARRIED 12/1/1889</u>		9. AGE last birthday <u>66</u> yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Assistant Railroad Training School</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>LONDON, ENGLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Robert James</u>				14. MOTHER'S MAIDEN NAME: <u>Elizabeth Armstrong</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, for ink.) (If Yes, give war or dates) <u>British Army</u>				17. INFORMANT & ADDRESS: <u>MARY C. ARMSTRONG - Mt. Wilson, Md.</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>443X</u>				DUE TO <u>Chronic Myocarditis</u>			
ANTECEDENT CAUSE (B)				DUE TO <u>Hypertension</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN. 3rd</u> , 19 <u>56</u> , to <u>JAN. 3rd</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JAN. 3rd</u> , 19 <u>56</u> , and that death occurred at <u>9:45 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>James G. Miller</u>		ADDRESS <u>Pikesville, Md.</u>		DATE SIGNED <u>1/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 6, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Wood Ridge Cemetery</u>		LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>JAN 5, 1956</u>		REGISTRAR'S SIGNATURE <u>Harvey A. Newell</u>		24. FUNERAL DIRECTOR <u>Frank H. Newell</u>		ADDRESS <u>Pikesville</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 9 1951

RECEIVED

00286

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

299

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

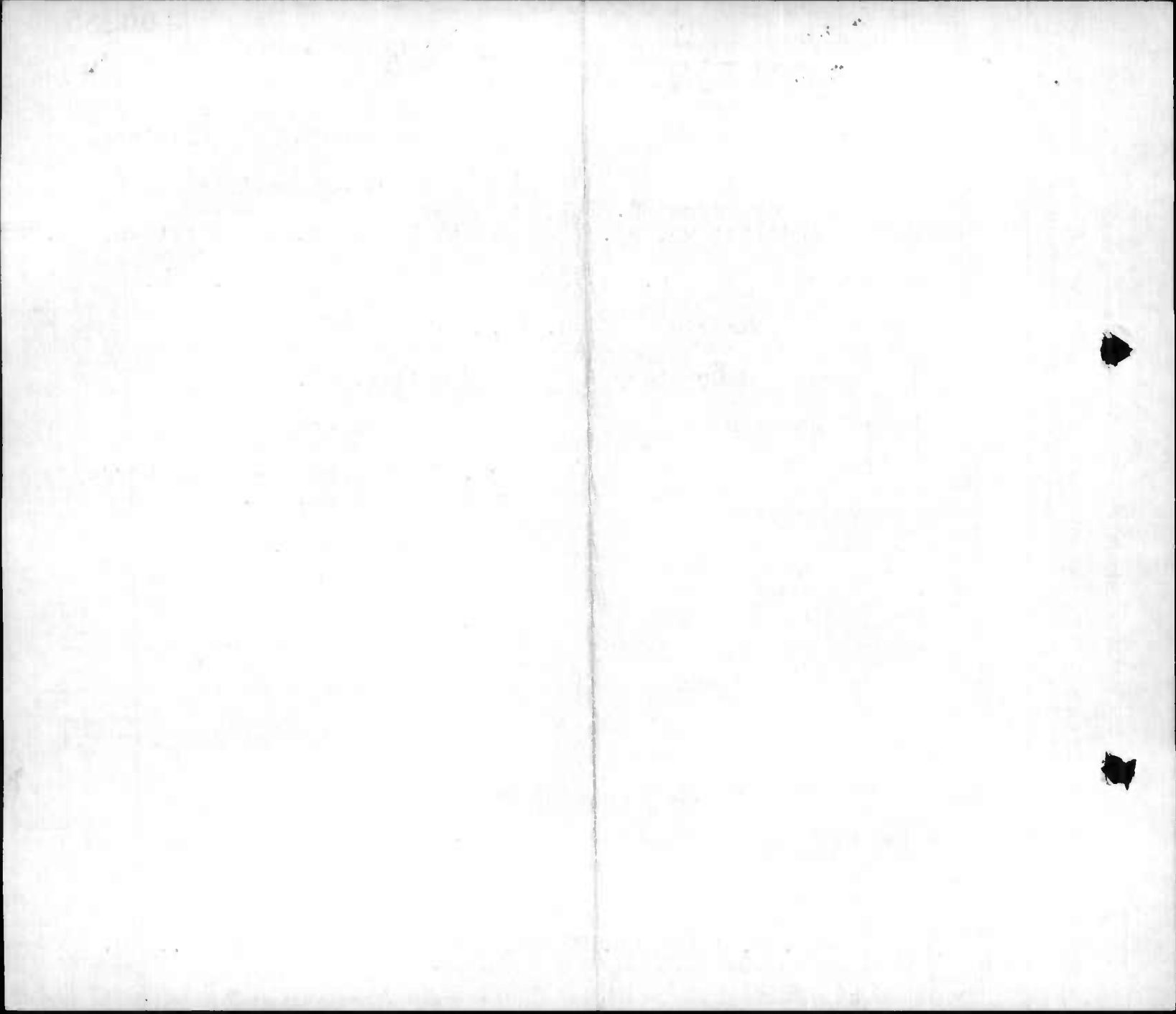
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural-Pikesville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Rural-Pikesville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Valley Forge Rd. Randallstown, Md.</b>		STREET ADDRESS (If rural give location) <b>Valley Forge Rd.-Randallstown, Md.</b>	
3. NAME OF DECEASED: (First) (Middle) (Last) <b>Stewart R. Johnson</b>		4. DATE OF DEATH: (Month) (Day) (Year) <b>Jan. 4, 1956</b>	
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>Colored</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>Jan. 14, 1910</b>
		9. AGE last birthday: <b>45</b> yrs.	IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>Cemetery</b>	11. BIRTHPLACE (State or foreign country): <b>Woodlawn, Md.</b>
13. FATHER'S NAME: <b>Dennis Johnson</b>		14. MOTHER'S MAIDEN NAME: <b>Clara Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
		17. INFORMANT & ADDRESS: <b>Mrs. Clara Johnson-Valley Forge</b>	

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE <b>443X</b>		
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(A) <b>Hypertensive C.O. disease - severe</b>		<b>5 years -</b>
DUE TO		
(B) <b>Long abscess - esp. chest</b>		
DUE TO		
(C) <b>Broncho-pulmonary fistula - &amp; Pneumothorax</b>		<b>1 month.</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Coronary heart failure, acute</b>		<b>1 day.</b>
19A. DATE OF OPERATION:	19B. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>

21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21F. HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <b>Dec. 24, 1955</b> , to <b>Jan. 4, 1956</b> , that I last saw the deceased alive on <b>Jan. 4, 1956</b> , and that death occurred at <b>2 P. M.</b> from the causes and on the date stated above.		
SIGNATURE <b>Thomas E. Wheeler</b>	ADDRESS <b>3601 Cypress Rd. - Baltimore</b>	DATE SIGNED <b>1-6-56</b>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	DATE THEREOF <b>Jan. 7, 1956</b>	NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cem</b>
		LOCATION (City, town, or county) (State) <b>Baltimore Co., Md.</b>
DATE REC'D BY LOCAL REGISTRAR <b>Jan. 7, 1956</b>	REGISTRAR'S SIGNATURE <b>R.W.</b>	24. FUNERAL DIRECTOR <b>HOME</b> ADDRESS <b>HOLLAND FUNERAL-1631 DRUID HILL AVE.</b>

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Somerset</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <b>Fort Howard</b>		<b>26 Days</b>		TOWN <b>Princess Anne</b>		<b>194-2</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Veterans Administration Hospital</b>				STREET ADDRESS (If rural give location) <b>RFD #1 Box 145</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>THOMAS</b> (Middle) (Last) <b>JONES, JR.</b>				(Month) (Day) (Year) <b>January 31 19 56</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>Male</b>	<b>Colored</b>	<b>Married</b>	<b>April 4, 1922</b>	<b>33</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Oyster Shucker</b>		<b>house Oyster packing</b>		<b>Princess Anne, Maryland</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>Thomas Jones</b>				<b>Bessie Jones</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>Yes</b>		<b>WW II</b>		<b>220-12-2168</b>			
				<b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						UNKNOWN	
591x IMMEDIATE CAUSE (A) <b>SUBACUTE GLOMERULONEPHRITIS</b>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
VA		M.					
22. I hereby certify that I attended the deceased from Jan. 5, 1956, to Jan. 31, 1956, and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)			
<b>DONALD D. MARK</b>				<b>VAH, FORT HOWARD, MARYLAND</b>			
M.D.				DATE SIGNED			
				<b>2/1/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>2/3/56</b>		<b>Mount Vernon Cemetery</b>		<b>Mount Vernon, Maryland</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>2/3/56</b>		<b>Lawson L. Fawcett</b>		<b>Charles R. Law, 802 Madison Ave., Baltimore, Md.</b>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

Shipped to: William James Funeral Home, Princess Anne, Md.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPT. OF HEALTH - BALTIMORE 10

Page 1 of 1

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL SOCIETY

16. SIGNATURE OF CHURCH

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF COFFIN

20. SIGNATURE OF CLOTHES

21. SIGNATURE OF CASK

22. SIGNATURE OF CASK

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BUREAU V. S.

FEB 6 1956

RECEIVED

NOTIFICATION

1. NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESSES  
13. SIGNATURE OF DECEASED  
14. SIGNATURE OF NEXT OF KIN  
15. SIGNATURE OF BURIAL SOCIETY  
16. SIGNATURE OF CHURCH  
17. SIGNATURE OF CEMETERY  
18. SIGNATURE OF FUNERAL HOME  
19. SIGNATURE OF COFFIN  
20. SIGNATURE OF CLOTHES  
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301

CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Prince Georges</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Owings Mills</b>		LENGTH OF STAY (in this place) <b>2 1/2 yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Hyattsville, Maryland</b> <b>16-15-2</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rosewood Training School</b>				STREET ADDRESS (If rural give location) <b>5604 30th Avenue</b>			
3. NAME OF DECEASED: (First) <b>Alan</b> (Middle) <b>Lee</b> (Last) <b>Josephson</b>			4. DATE (Month) (Day) (Year) OF DEATH: <b>1</b> <b>26</b> <b>19 56</b>				
5. SEX: <b>male</b>	6. COLOR OR RACE: <b>white</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>single</b>	8. DATE OF BIRTH: <b>10/23/47</b>		9. AGE last birthday <b>8</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>--</b>			10B. KIND OF BUSINESS OR INDUSTRY: <b>--</b>		11. BIRTHPLACE (State or foreign country): <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME: <b>Gilbert Cecil Josephson</b>				14. MOTHER'S MAIDEN NAME: <b>Rosalee Strasburger</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>--</b>			16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT & ADDRESS: <b>Rosewood Records Owings Mills, Md.</b>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							<b>4 days</b>
IMMEDIATE CAUSE <b>491X</b>			(A) <b>Broncho-Pneumonia</b>				
ANTECEDENT CAUSE (S):			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) DUE TO				
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Cerebral Spastic Paralysis</b>							<b>since birth</b>
19A. DATE OF OPERATION: <b>2</b>			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <b>1/25/56</b> , 19 <b>56</b> , to <b>1/26/56</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1/26</b> , 19 <b>56</b> , and that death occurred at <b>4:20 P.M.</b> , from the causes and on the date stated above.							
SIGNATURE <b>Harry B. Butler</b>			ADDRESS <b>Owings Mills, Md.</b>			DATE SIGNED <b>27 Jan 56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		DATE THEREOF <b>Jan. 30, 1956</b>	NAME OF CEMETERY OR CREMATORY <b>Green Mount</b>		LOCATION (City, town or county) (State) <b>Baltimore, Md.</b>		
DATE REC'D BY LOCAL REGISTRAR <b>1-29-56</b>		REGISTRAR'S SIGNATURE <b>Harry B. Butler</b>		24. FUNERAL DIRECTOR ADDRESS <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 1 1956

BUREAU V. S.

302

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00289

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. NAME OF DECEASED  
(Type or Print)

KECZMERSKI, JOHN F.

2. DATE  
OF  
DEATH

1-21-56

3. PLACE OF DEATH:

a. Baltimore City, Maryland

County

b. FULL NAME OF  
HOSPITAL OR  
INSTITUTION

7524 BELAIR RD.

4. USUAL RESIDENCE (Where deceased lived, if institution: residence  
before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

OVERLEA

D. STREET ADDRESS (If rural, give location)

7524 BELAIR RD.

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. SINGLE, MARRIED,  
WIDOWED, DIVORCED (Specify)

MARRIED

8. DATE OF BIRTH

FEB. 3, 1907

9. AGE (In years  
last birthday)

48

If Under 1 Year  
Months: DaysIf Under 24 Hours  
Hours: Min.10A. USUAL OCCUPATION (Give kind of  
work done during most of working life, even if retired)

SALES

10B. KIND OF BUSINESS OR  
INDUSTRY

RETAIL LIQUOR

11. BIRTHPLACE (State or foreign country)

BALTIMORE, MARYLAND

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

DANIEL KECZMERSKI

14. MOTHER'S MAIDEN NAME

ANNA KOFFMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown)

(If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

17. INFORMANT

DECEASED

ADDRESS

SAME

18.

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthenia, etc. It means the disease,  
injury or complication which caused death.)

CAUSE OF DEATH

(A) METASTATIC CARCINOMA

DUE TO

INTERVAL BETWEEN  
ONSET AND DEATH

7 MONTHS

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B) CARCINOMA OF SIGMOID

DUE TO

1 YR.

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE  
DISEASE OR CONDITION CAUSING IT.IF OPERATION WAS RELATED TO  
CAUSE OF DEATH, ENTER IN  
PART I OR PART II

19A. DATE OF OPERATION

10-1-55

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

EXPLORATION

20. AUTOPSY?

YES ☐ NO ☐21D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY

21E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 9 - 20 19 55 to  
JANUARY 21 19 56, that (I) (we) last saw the deceased alive on JANUARY 21 19 56,  
and that death occurred at 5:15 P.m., from the causes and on the date stated above.

23A. SIGNATURE

Paul G. Harold

23B. ADDRESS

10 W. Madison St.

23C. DATE SIGNED

January 22, 1956

24A. BURIAL, CREMA-  
TION, REMOVAL (Specify)

BURIAL

24B. DATE

JAN 25 56

24C. NAME OF CEMETERY OR CREMATORY

MORELAND MEMORIAL PARK

24D. LOCATION (City, town, or county)

TAYLOR AVE

(State)

MD

DATE RECEIVED BY  
LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

A.W. Helrich

25. FUNERAL DIRECTOR

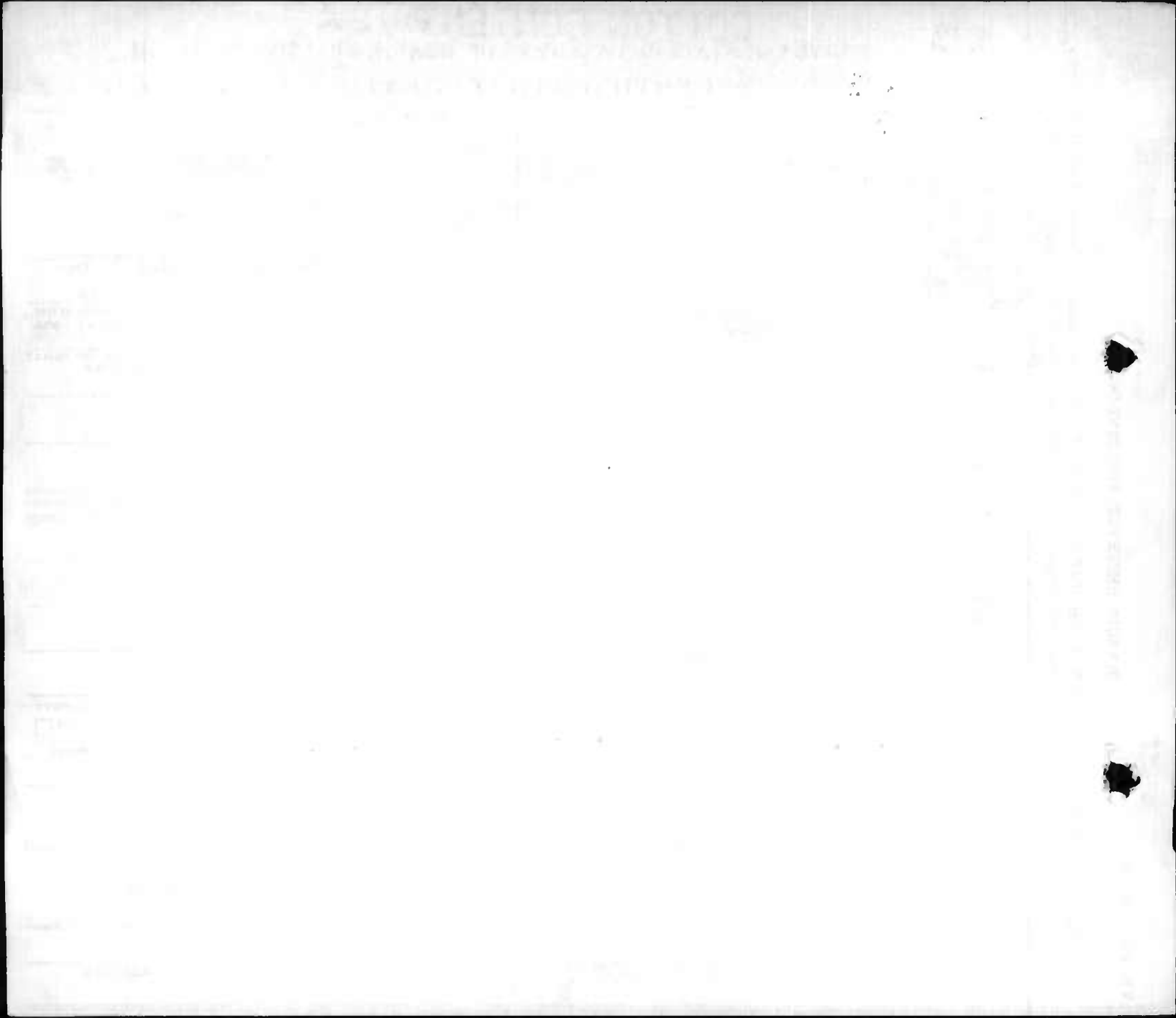
L. B. BIRD

ADDRESS

7110 BELAIR RD

THIS IS A PERMANENT RECORD. PLEASE TYPE, OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN. Every item of information be carefully supplied. Physicians: please write the causes of death clearly and legibly. HIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

ML CERTIFICATION





1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

00290

Reg. Dist. No.....

1. PLACE OF DEATH COUNTY <u>BALTO.</u> <u>7912 Ruxway Road</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>RUYTON</u> [4] OR TOWN <u>RUYTON</u> [4] HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 SORENSON NURSING HOME.</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MD</u> COUNTY <u>—</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTO. 13</u> OR TOWN <u>3V01-4</u> STREET ADDRESS (If rural give location) <u>1725 DARLEY AVE.</u> ✓			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>LEONA</u> <u>LOVE</u> <u>KEISTER</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-26-1956</u>			
5. SEX <u>FEM. WHITE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10 JUNE 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min. <u>4</u> <u>15</u> <u>—</u> <u>—</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOME</u>		11. BIRTHPLACE (State or foreign country) <u>W. VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ALONZO BUTCHER</u>				14. MOTHER'S MAIDEN NAME <u>LYDIA (?)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>ROBT. W. KEISTER 3405 SOLLERS POINT RD.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
199.8 IMMEDIATE CAUSE (A) <u>Carcinoma gallbladder metastatic</u>						<u>2 years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Carcinoma liver with metastasis</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Abscess upper right abdominal quadrant</u>						<u>1 month</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Acathectic jaundice</u>						<u>2 months</u>	
19a. DATE OF OPERATION <u>Dec 1955</u>		19b. MAJOR FINDINGS OF OPERATION <u>Right upper abdominal laparotomy</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <u>no</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>no injury</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>no injury</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work <u>no injury</u>		21f. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Jan 17, 1956</u> , to <u>Jan 26, 1956</u> , that I last saw the deceased live on <u>Jan 20, 1956</u> , and that death occurred at <u>8:30</u> M., from the causes and on the date stated above.							
SIGNATURE <u>James Graham Martin</u>				ADDRESS (Street, city, town, state) <u>516 Cathedral Street</u>		DATE SIGNED <u>I-27-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-30-56</u>	NAME OF CEMETERY OR CREMATORY <u>MEADOWRIDGE</u>		LOCATION (City, town, or county) (State) <u>DORSEY, MD</u>		
24. REC'D BY REGISTRAR <u>JAN 30 1956</u>		REGISTRAR'S SIGNATURE <u>Michael Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Bruce Pundley of Burial, Md.</u>			

# CERTIFICATE OF DEATH

00520

Jan 28 1956

1. FULL NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESS

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL OFFICIAL

16. SIGNATURE OF FUNERAL HOME

17. SIGNATURE OF CEMETERY

18. SIGNATURE OF CHURCH

19. SIGNATURE OF MINISTRY

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

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31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

BUREAU V. S.

JAN 30 1956

RECEIVED

1. FULL NAME OF DECEASED  
2. SEX  
3. AGE  
4. DATE OF BIRTH  
5. PLACE OF BIRTH  
6. OCCUPATION  
7. CAUSE OF DEATH  
8. PLACE OF DEATH  
9. TIME OF DEATH  
10. SIGNATURE OF PHYSICIAN  
11. SIGNATURE OF REGISTRAR  
12. SIGNATURE OF WITNESS  
13. SIGNATURE OF DECEASED  
14. SIGNATURE OF NEXT OF KIN  
15. SIGNATURE OF BURIAL OFFICIAL  
16. SIGNATURE OF FUNERAL HOME  
17. SIGNATURE OF CEMETERY  
18. SIGNATURE OF CHURCH  
19. SIGNATURE OF MINISTRY  
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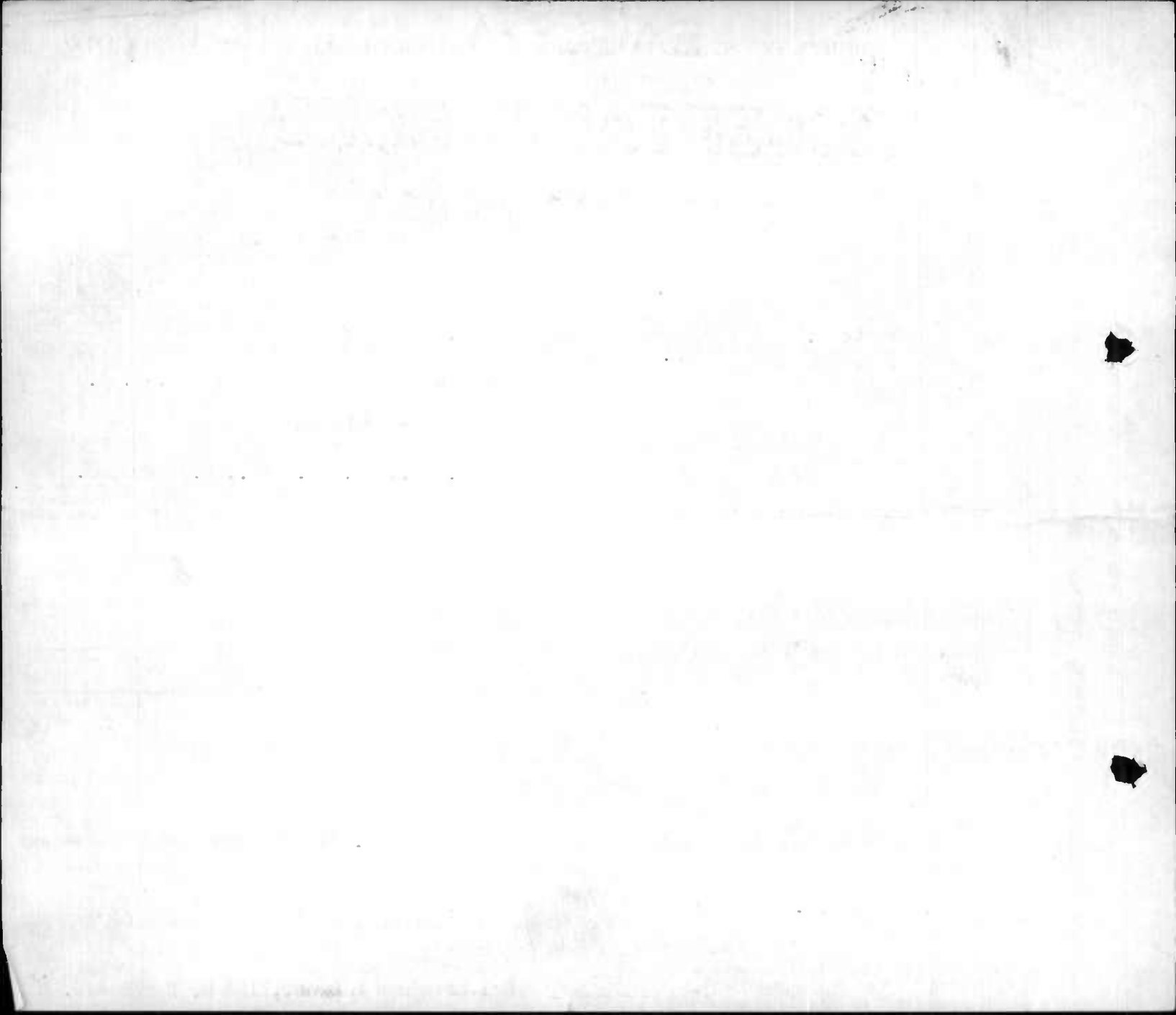
## CERTIFICATE OF DEATH

Reg. Dist. No. 48

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>22 Days</u>		TOWN <u>Baltimore</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>3801 Fernhill Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
(Type or Print) <u>ANTON P. KOPETZA</u>				OF DEATH: <u>January 31, 19 56</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>December 25, 1898</u>	<u>57</u> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Painter</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Russia</u>	
13. FATHER'S NAME: <u>Peter Kopetza</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) (If Yes, give war or dates of service) <u>WW I</u>				16. SOCIAL SECURITY NO. <u>219-10-8936</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>ADVANCED FIBROCASEOUS TUBERCULOSIS,</u>							
ANTECEDENT CAUSE (S) <u>XEROX LUNGS</u>							UNKNOWN
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>				19B. MAJOR FINDINGS OF OPERATION			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While Not while at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 9</u> , 1956, to <u>Jan. 31, 1956</u> , and that death occurred at <u>8:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>DONALD D. MARK, M.D.</u>				ADDRESS <u>M. D. VAH, FORT HOWARD, MARYLAND</u>		DATE SIGNED <u>2/2/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2/3/56</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-3-56</u>		<u>[Signature]</u>		<u>Sol Levinson &amp; Bros.,</u>		<u>1126 W. North Ave. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



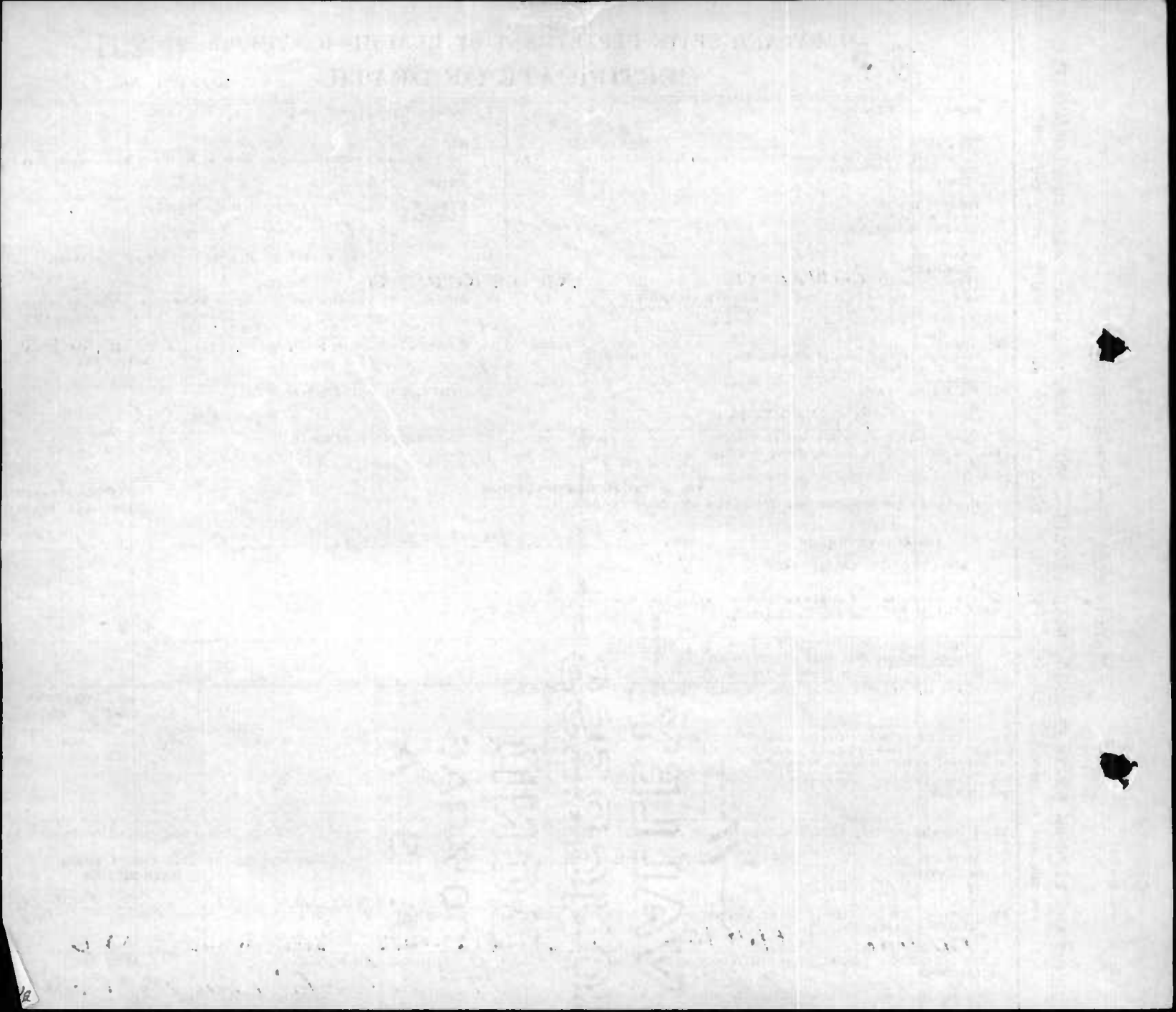
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 355 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 100291

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u> COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>MOUNT WILSON</u>		<u>141 days.</u>		OR TOWN <u>BALTIMORE 24</u> <u>3Y01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MOUNT WILSON STATE HOSPITAL</u>				STREET ADDRESS (If rural give location) <u>3609 FOSTER AVENUE</u> ✓			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>LAWRENCE</u> <u>KWIATKOWSKI</u>				<u>1 - 12 - 1956</u>			
5. SEX: <u>MALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>SINGLE</u>		8. DATE OF BIRTH: <u>8 - 11 - 05</u>	
				9. AGE last birthday <u>50</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>LABOURER</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>FACTORY</u>		11. BIRTHPLACE (State or foreign country): <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME: <u>JAMES KWIATKOWSKI</u>				14. MOTHER'S MAIDEN NAME: <u>ELIZABETH TOPELSKA</u>			
15. Was DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-07-7427</u>		17. INFORMANT & ADDRESS: <u>HELEN HARNE SISTER 3609 FOSTER AVE BALTIMORE 24 MD.</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						(A) <u>163X</u> <u>CARCINOMA OF LUNG</u>	
IMMEDIATE CAUSE						DUE TO	
ANTECEDENT CAUSE (S):						(B) <u>5 months</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>8-24</u> , 1955, to <u>1-12</u> , 1956, that I last saw the deceased alive on <u>1-11</u> , 1956, and that death occurred at <u>12:50AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>William Nowinski</u>		ADDRESS <u>M. D. MOUNT WILSON MARYLAND</u>		DATE SIGNED <u>1-12-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1/14/56</u>		NAME OF CEMETERY OR CREMATORY <u>ST. STANISLAUS</u>		LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/13/56</u>		REGISTRAR'S SIGNATURE <u>A. W. Hedrick</u>		24. FUNERAL DIRECTOR ADDRESS <u>M. J. Sadowski &amp; Son, 1808 Eastern A</u>			





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## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

X TOWN Rural: Towson

LENGTH OF STAY

(in this place)

11 mo 20 dy

HOSPITAL OR INSTITUTION OR

01 STREET ADDRESS Eudowood Sanatorium  
Towson 4, Maryland

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY

CITY (If outside corporate limits, write RURAL and give nearest town)

OR TOWN Baltimore 3401-4

STREET ADDRESS (If rural give location)

445 N. Ellwood Ave.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

William B. Lambie

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

Jan 27 19 56

## 5. SEX:

M

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

married

## 8. DATE OF BIRTH:

July 30 1888

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

71 yrs. Months Days Hours Min.

## 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired:

Retired meat cutter

## 10b. KIND OF BUSINESS OR INDUSTRY:

A. &amp; P. Co

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

John D. Lambie

## 14. MOTHER'S MAIDEN NAME:

Emma Rogge

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no no

## 16. SOCIAL SECURITY No.:

216-031-588

## 17. INFORMANT &amp; ADDRESS:

Mr. William K. Lambie - 445 N. Ellwood Ave.

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

002 X

Immediate cause

(a) Pulmonary Tuberculosis

DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

2 yrs

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

## 19a. DATE OF OPERATION:

0

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR?

## 22. I hereby certify that I attended the deceased from 7.4.1954 to Jan 27, 1956, that I last saw the deceased

alive on 25 Jan 1956, and that death occurred at 8.15 A.M. from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Melvin B. Kress M.D. Eudowood Sanatorium - Towson 4, Md.

## 23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## DATE THEREOF

1/30/56

## NAME OF CEMETERY OR CREMATORY

Holy Redeemer Cem.

## LOCATION (City, town, or county)

Balto., Md.

## (State)

## DATE REC'D BY LOCAL REGISTRAR

Jan 28 1956

## REGISTRAR'S SIGNATURE

R.W.

## 24. FUNERAL DIRECTOR

Thm. J. Lickner &amp; Sons - Balto 17

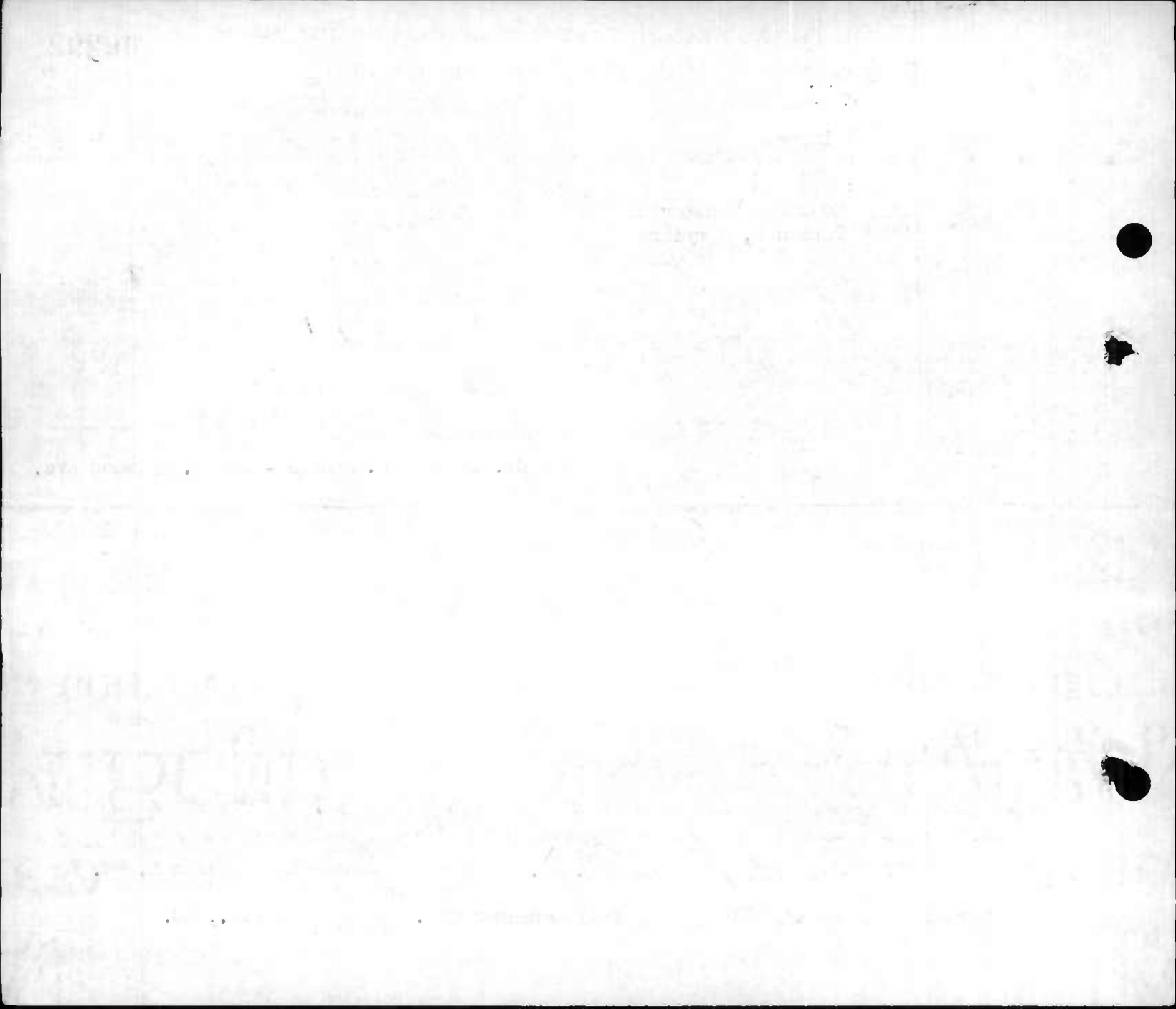
## ADDRESS

rmd.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00293

307

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Parkville</b>				TOWN <b>Parkville</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>9003 Harford Road</b>				STREET ADDRESS (If rural give location) <b>9003 Harford Road</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Mrs. Anna Lane</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>January 30th 19 56</b>			
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>married</b>		<b>8. DATE OF BIRTH</b> <b>July 25, 1895</b>	
						<b>9. AGE last birthday</b> <b>60</b> yrs.	
						IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>at home</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>	
						<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Mr. Frank Simacek</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sophia</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Lester Lane, 9003 Harford Road</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>581.0 IMMEDIATE CAUSE (A)</b> <b>Cachexia and debilitation</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>3 mos.</b>			
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B)</b> <b>Dehydration &amp; anemia</b>							
<b>(C)</b> <b>Cirrhotic liver</b>				<b>1 yr.</b>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <b>Arteriosclerosis</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <b>Jan 25, 1956</b> , <b>to</b> <b>Jan 30, 1956</b> , <b>that I last saw the deceased alive on</b> <b>Jan 28, 1956</b> , <b>and that death occurred at</b> <b>3:4</b> <b>M.</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Frank A. Kasick</b> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>9005 Harford Rd Baltimore</b> <b>DATE SIGNED</b> <b>1/30/56</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>Feb. 2, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Dr. A. M. Bacon</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>			
<b>DATE</b> <b>Jan. 31, 1956</b>							



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00294

206

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Arbutus</u>		<u>15 yrs</u>		TOWN <u>Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1213 Maiden Choice Lane</u>				STREET ADDRESS (If rural give location) <u>1213 Maiden Choice Lane</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Charles</u> (Middle) <u>J.</u> (Last) <u>Langhirt</u>				(Month) <u>Jan.</u> (Day) <u>30</u> (Year) <u>1956</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 16, 1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
							Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Int. Revenue</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sabastian Langhirt</u>				14. MOTHER'S MAIDEN NAME <u>Rosa</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>212-07-0863</u>		17. INFORMANT & ADDRESS <u>Miss Grace Langhirt, 1213 Maiden Choice Lane.</u>			
		(If Yes, give war or dates of service)					
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
151X IMMEDIATE CAUSE (A) <u>Hemorrhage G.I. Tract</u>						INTERVAL BETWEEN ONSET AND DEATH <u>15 Days</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cancer of Stomach</u>						<u>3 month</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Cycical RT Tuberculosis</u>						<u>unknown</u>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 19</u> , 19 <u>56</u> , to <u>Jan 30</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/26</u> , 19 <u>56</u> , and that death occurred at <u>4:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Cliff Davis Jr.</u>				ADDRESS (Street, city, town, state) <u>4605 Edmondson Ave</u>		DATE SIGNED <u>2/1/56</u>	
M.D. <u>4605 Edmondson Ave</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Feb. 2/56</u>		NAME OF CEMETERY OR CREMATORY <u>Louisa Park</u>		LOCATION (City, town, or county) <u>Balto. Md.</u>	
24. REC'D BY REGISTRAR <u>Feb. 1 1956</u>		REGISTRAR'S SIGNATURE <u>Harry H. Witte</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Harry H. Witte</u>		ADDRESS <u>4101 Edmondson Ave</u>	
DATE							

100-807

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 15

# CERTIFICATE OF DEATH

100-808

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

AGE

DATE OF BIRTH

PLACE OF BIRTH

CAUSE OF DEATH

IMMEDIATE CAUSE

UNDERLYING CAUSE

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

SEX

BUREAU V. S.

FEB 2 1956

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MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 15



308

## CERTIFICATE OF DEATH

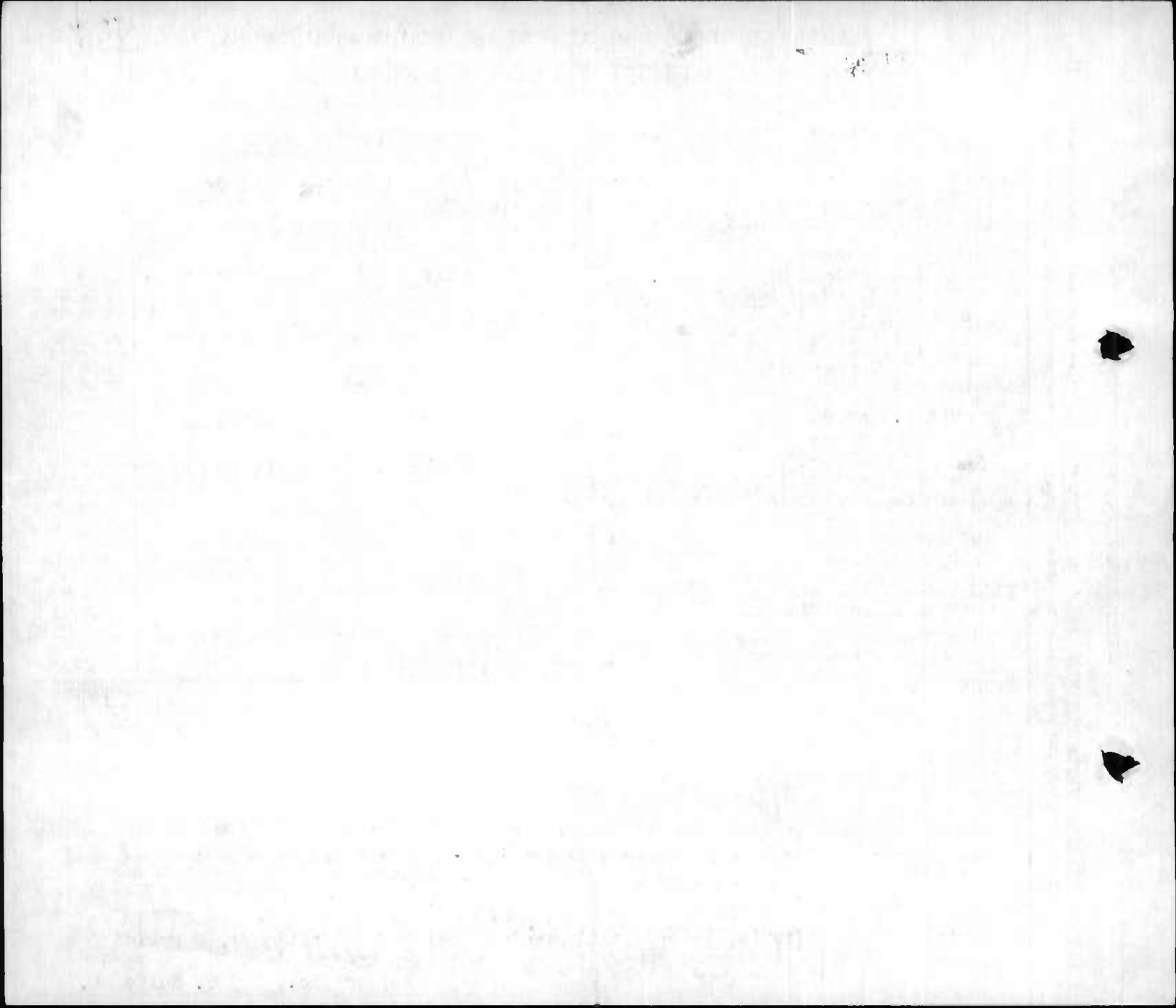
Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52</u> TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3701-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14</u> <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>1910 Park Avenue</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>John</u> <u>B.</u> <u>Larsen</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>January 6,</u> <u>1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>3-12-1889</u>
9. AGE last birthday <u>66</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Coppersmith</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>August A. Larsen</u>		14. MOTHER'S MAIDEN NAME: <u>Elizabeth Harble</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <u>Yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>490X</u> <u>Lobar pneumonia</u>			<u>6 days</u>
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Suppurative parotitis</u>			<u>2 days</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-11-</u> , 19 <u>53</u> to <u>1-6-</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-6-56</u> , 19 <u>56</u> , and that death occurred at <u>3:15 PM</u> , from the causes and on the date stated above.			
SIGNATURE <u>S. L. Wachler</u>		DATE SIGNED <u>1-6-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 10, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/9/56</u>		24. FUNERAL DIRECTOR ADDRESS <u>Lilly &amp; Zeiler Inc., 403 S. Wolfe St.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

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309

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ruxton</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorrenson Nursing Home 7912 Ruxway Road</u>				STREET ADDRESS (If rural give location) <u>Broadview Apartments</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH: Jan. 12, 19 56			
FLORENCE MAY LAYMAN							
5. SEX: female	6. COLOR OR RACE: white	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): single	8. DATE OF BIRTH: May 16, 1874	9. AGE last birthday: 81 yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret. School Teacher</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Education</u>		11. BIRTHPLACE (State or foreign country): <u>Chesterville, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>							
13. FATHER'S NAME: <u>Henry Clay Layman</u>				14. MOTHER'S MAIDEN NAME: <u>Susanna Brock Ford</u>			
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unk.) <u>---</u> (If Yes, give war or dates of service) <u>---</u>				16. SOCIAL SECURITY NO. <u>---</u>			
17. INFORMANT & ADDRESS: <u>Allan H. Layman, 1535 East 35th St.</u>							
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
292.2 IMMEDIATE CAUSE (A) <u>Hemolytic anemia</u>						6 wks -	
ANTECEDENT CAUSE (B) <u>Unknown cause</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral arterio sclerosis</u>						none yr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 12, 1956, to Jan. 12, 1956, that I last saw the deceased alive on Jan. 12, 1956, and that death occurred at 12:30 AM, from the causes and on the date stated above.							
SIGNATURE <u>Ernest C. Brown</u>		ADDRESS <u>M. D. 1101 N. Calvert St</u>		DATE SIGNED <u>Jan 15, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/14/56</u>		NAME OF CEMETERY OR CREMATORY <u>Stillpond Cemetery</u>		LOCATION (City, town, or county) (State) <u>Still Pond, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/18/56</u>		REGISTRAR'S SIGNATURE <u>H. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	

WATER RESOURCES DIVISION

NAME	ADDRESS	CITY	STATE	ZIP
Mr. J. W. Smith	123 Main St.	Denver	CO	80202
Mr. R. L. Jones	456 Elm St.	Chicago	IL	60601
Mr. T. E. Brown	789 Oak St.	San Francisco	CA	94102
Mr. H. G. White	101 Pine St.	New York	NY	10001
Mr. K. M. Green	202 Cedar St.	Los Angeles	CA	90001
Mr. N. P. Black	303 Birch St.	Portland	OR	97201
Mr. Q. R. Gray	404 Spruce St.	Seattle	WA	98101
Mr. S. T. Hall	505 Willow St.	Phoenix	AZ	85001
Mr. U. V. King	606 Ash St.	San Diego	CA	92101
Mr. W. X. Lee	707 Hickory St.	San Jose	CA	95101
Mr. Y. Z. Scott	808 Maple St.	San Antonio	TX	78201
Mr. A. B. Adams	909 Poplar St.	Fort Worth	TX	76101
Mr. C. D. Baker	1010 Walnut St.	Dallas	TX	75201
Mr. E. F. Carter	1111 Chestnut St.	Houston	TX	77001
Mr. G. H. Evans	1212 Locust St.	Memphis	TN	38101
Mr. I. J. Fisher	1313 Mulberry St.	Nashville	TN	37201
Mr. L. K. Gibson	1414 Myrtle St.	Indianapolis	IN	46201
Mr. M. N. Hart	1515 Olive St.	Columbus	OH	43201
Mr. O. P. Ingram	1616 Pearl St.	Cincinnati	OH	45201
Mr. R. Q. Jordan	1717 Pine St.	Cleveland	OH	44101
Mr. S. R. Keller	1818 Spruce St.	Dayton	OH	45401
Mr. T. U. Lester	1919 Walnut St.	Richmond	VA	23201
Mr. V. W. Martin	2020 Elm St.	Pittsburgh	PA	15201
Mr. X. Y. Nelson	2121 Oak St.	Philadelphia	PA	19101
Mr. Z. A. Owen	2222 Pine St.	Washington	DC	20001
Mr. B. C. Parker	2323 Cedar St.	Baltimore	MD	21201
Mr. D. E. Quinn	2424 Birch St.	Boston	MA	02101
Mr. F. G. Roberts	2525 Spruce St.	New Haven	CT	06501
Mr. H. I. Scott	2626 Willow St.	Bridgeport	CT	06601
Mr. J. K. Taylor	2727 Ash St.	Stamford	CT	06901
Mr. L. M. Vance	2828 Hickory St.	Greenwich	CT	06830
Mr. N. O. Webb	2929 Maple St.	Westport	CT	06880
Mr. P. Q. White	3030 Poplar St.	Stamford	CT	06901
Mr. R. S. Black	3131 Walnut St.	Stamford	CT	06901
Mr. T. V. Green	3232 Chestnut St.	Stamford	CT	06901
Mr. U. W. Hall	3333 Locust St.	Stamford	CT	06901
Mr. V. X. King	3434 Mulberry St.	Stamford	CT	06901
Mr. W. Y. Lee	3535 Myrtle St.	Stamford	CT	06901
Mr. X. Z. Scott	3636 Olive St.	Stamford	CT	06901
Mr. Y. A. Adams	3737 Pearl St.	Stamford	CT	06901
Mr. Z. B. Baker	3838 Pine St.	Stamford	CT	06901
Mr. A. C. Carter	3939 Spruce St.	Stamford	CT	06901
Mr. B. D. Evans	4040 Willow St.	Stamford	CT	06901
Mr. C. E. Fisher	4141 Ash St.	Stamford	CT	06901
Mr. D. F. Gibson	4242 Hickory St.	Stamford	CT	06901
Mr. E. G. Hart	4343 Maple St.	Stamford	CT	06901
Mr. F. H. Ingram	4444 Poplar St.	Stamford	CT	06901
Mr. G. I. Jordan	4545 Walnut St.	Stamford	CT	06901
Mr. H. J. Keller	4646 Chestnut St.	Stamford	CT	06901
Mr. I. K. Lester	4747 Locust St.	Stamford	CT	06901
Mr. J. L. Martin	4848 Mulberry St.	Stamford	CT	06901
Mr. K. M. Nelson	4949 Myrtle St.	Stamford	CT	06901
Mr. L. N. Owen	5050 Olive St.	Stamford	CT	06901
Mr. M. O. Parker	5151 Pearl St.	Stamford	CT	06901
Mr. N. P. Quinn	5252 Pine St.	Stamford	CT	06901
Mr. O. Q. Roberts	5353 Spruce St.	Stamford	CT	06901
Mr. P. R. Scott	5454 Willow St.	Stamford	CT	06901
Mr. Q. S. Taylor	5555 Ash St.	Stamford	CT	06901
Mr. R. T. Vance	5656 Hickory St.	Stamford	CT	06901
Mr. S. U. Webb	5757 Maple St.	Stamford	CT	06901
Mr. T. V. White	5858 Poplar St.	Stamford	CT	06901
Mr. U. W. Black	5959 Walnut St.	Stamford	CT	06901
Mr. V. X. Green	6060 Chestnut St.	Stamford	CT	06901
Mr. W. Y. Hall	6161 Locust St.	Stamford	CT	06901
Mr. X. Z. King	6262 Mulberry St.	Stamford	CT	06901
Mr. Y. A. Lee	6363 Myrtle St.	Stamford	CT	06901
Mr. Z. B. Scott	6464 Olive St.	Stamford	CT	06901
Mr. A. C. Adams	6565 Pearl St.	Stamford	CT	06901
Mr. B. D. Baker	6666 Pine St.	Stamford	CT	06901
Mr. C. E. Carter	6767 Spruce St.	Stamford	CT	06901
Mr. D. F. Evans	6868 Willow St.	Stamford	CT	06901
Mr. E. G. Fisher	6969 Ash St.	Stamford	CT	06901
Mr. F. H. Gibson	7070 Hickory St.	Stamford	CT	06901
Mr. G. I. Hart	7171 Maple St.	Stamford	CT	06901
Mr. H. J. Ingram	7272 Poplar St.	Stamford	CT	06901
Mr. I. K. Jordan	7373 Walnut St.	Stamford	CT	06901
Mr. J. L. Keller	7474 Chestnut St.	Stamford	CT	06901
Mr. K. M. Lester	7575 Locust St.	Stamford	CT	06901
Mr. L. N. Martin	7676 Mulberry St.	Stamford	CT	06901
Mr. M. O. Nelson	7777 Myrtle St.	Stamford	CT	06901
Mr. N. P. Owen	7878 Olive St.	Stamford	CT	06901
Mr. O. Q. Parker	7979 Pearl St.	Stamford	CT	06901
Mr. P. R. Quinn	8080 Pine St.	Stamford	CT	06901
Mr. Q. S. Roberts	8181 Spruce St.	Stamford	CT	06901
Mr. R. T. Scott	8282 Willow St.	Stamford	CT	06901
Mr. S. U. Taylor	8383 Ash St.	Stamford	CT	06901
Mr. T. V. Vance	8484 Hickory St.	Stamford	CT	06901
Mr. U. W. Webb	8585 Maple St.	Stamford	CT	06901
Mr. V. X. White	8686 Poplar St.	Stamford	CT	06901
Mr. W. Y. Black	8787 Walnut St.	Stamford	CT	06901
Mr. X. Z. Green	8888 Chestnut St.	Stamford	CT	06901
Mr. Y. A. Hall	8989 Locust St.	Stamford	CT	06901
Mr. Z. B. King	9090 Mulberry St.	Stamford	CT	06901
Mr. A. C. Lee	9191 Myrtle St.	Stamford	CT	06901
Mr. B. D. Scott	9292 Olive St.	Stamford	CT	06901
Mr. C. E. Adams	9393 Pearl St.	Stamford	CT	06901
Mr. D. F. Baker	9494 Pine St.	Stamford	CT	06901
Mr. E. G. Carter	9595 Spruce St.	Stamford	CT	06901
Mr. F. H. Evans	9696 Willow St.	Stamford	CT	06901
Mr. G. I. Fisher	9797 Ash St.	Stamford	CT	06901
Mr. H. J. Gibson	9898 Hickory St.	Stamford	CT	06901
Mr. I. K. Hart	9999 Maple St.	Stamford	CT	06901

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTO.</b>		MARYLAND		STATE <b>MD.</b>		COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
52 <b>CATONSVILLE</b>		7 yrs		BALTO.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 <b>Spring Grove Hospital</b>				<b>Gwynn Oak Ave. 6 Liberty Hts.</b>			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<b>JOHN B. LECKNER</b>				<b>1-3-56 19</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 MRS.	
<b>M</b>	<b>W</b>	<b>M</b>	<b>2-20-1888</b>	<b>67 yrs.</b>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>Horse Shder</b>				<b>Maryland</b>		<b>U.S.A.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Lewis Leckner</b>				<b>Catherine Ward</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>unk</b>				<b>Unknown</b>		<b>Spring Grove Hosp.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE							
(A) <b>Cerebral Thrombosis</b>							
DUE TO							
ANTECEDENT CAUSE (S)							
(B) <b>Cerebral Arteriosclerosis</b>							
DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH							
<b>Arteriosclerosis Cardiovascular disease</b>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>7-1-53</b> to <b>1-3-56</b> that I last saw the deceased alive on <b>1-3-56</b> and that death occurred at <b>6:45 PM</b> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<b>Stella Wachster</b>		<b>Spring Grove Hosp.</b>		<b>1-3-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1/6/56</b>		<b>London Park Cemetery</b>		<b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>Jan 4, 56</b>		<b>A. N. Heebich</b>		<b>Wm. Cook, Inc.</b>		<b>1217 St Paul St</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

REPORT OF THE COMMISSIONER OF PUBLIC HEALTH

1910

REPORT OF THE COMMISSIONER OF PUBLIC HEALTH

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## CERTIFICATE OF DEATH

Reg. Dist. No. 44...

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>BALTIMORE</b>	MARYLAND	STATE <b>MARYLAND</b>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR	
TOWN <b>FORT HOWARD,</b>	<b>7 DAYS</b>	TOWN <b>BALTIMORE #2</b>	<b>3V01.4</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural give location)	
<b>50 VETERANS ADMINISTRATION HOSPITAL</b>		<b>608 STERLING STREET</b>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<b>WILLIAM N. LeCOURT</b>		DEATH: <b>JANUARY 13 19 56</b>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<b>MALE</b>	<b>COLORED</b>	<b>WIDOWED</b>	<b>OCTOBER 16, 1888</b>
9. AGE last birthday		IF UNDER 1 YEAR Months Days Hours Min.	
<b>67 yrs.</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<b>PORTER</b>		<b>HOSPITAL</b>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<b>PHILADELPHIA, PENNSYLVANIA</b>		<b>U.S.A</b>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<b>GEORGE LeCOURT</b>		<b>BELLA YOUNG</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.	
<b>YES WW I</b>		<b>UNKNOWN</b>	
17. INFORMANT & ADDRESS:			
<b>CLIN. REC., VET. ADM. HOSP., FT. HOWARD, MD.</b>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <b>CARCINOMATOSIS</b>		<b>9 Months</b>	
DUE TO			
ANTECEDENT CAUSE (B) <b>ADENOCARCINOMA OF RECTUM</b>		<b>UNKNOWN</b>	
DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from Jan. 6, 1956, to Jan. 13, 1956, that I saw the deceased alive on Jan. 13, 1956, and that death occurred at 10:45 AM from the causes and on the date stated above.			
SIGNATURE <b>Irving Freeman</b>		ADDRESS <b>VAH Ft. Howard, Md</b>	
DATE SIGNED <b>1/13/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
<b>BURIAL</b>		<b>Baltimore National Cemetery Balto. Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>January 14 1955</b>		REGISTRAR'S SIGNATURE <b>R.W.</b>	
24. FUNERAL DIRECTOR		ADDRESS	
<b>Joseph G. Locks, Jr</b>		<b>1304 N. Central AVE Balto. Md</b>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

00299

Item 18 Film G191 1-23-56 am

312

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 3

1. PLACE OF DEATH: COUNTY <u>Baltimore</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>BALTO.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u> (22)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove State Hospital</u>		STREET ADDRESS (If rural, give location) <u>6504 Colgate Avenue</u>	
3. NAME OF DECEASED (First) <u>Antonio</u> (Middle) <u>MARTINEZ</u> (Last) <u>Lerio</u>		4. DATE OF DEATH (Month) <u>January</u> (Day) <u>11</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>6-13-1903</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Pin Mill Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL MFR.</u>	11. BIRTHPLACE (State or foreign country) <u>Spain</u>
13. FATHER'S NAME <u>Martius Lerio</u>		14. MOTHER'S MAIDEN NAME <u>Mary?</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> <u>No</u>		17. INFORMANT AND ADDRESS <u>Records Spring Grove State Hospital</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a) PENDING Congestive heart failure

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) Acute coronary thrombosis

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☒ No ☐21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.PLACE (Home, farm, factory, street, OF office bldg., etc.)  
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☒, accident ☐, suicide ☐, homicide ☐, undetermined ☐.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Dr. M. Kieffer, M.D. 1010 Leeds Avenue  
Arbutus, Maryland

1-12-56

## 23. BURIAL, CREMATION, DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

JAN 16 1956

W. E. HarryWalter Drake Bradley, DUNDALK, Md.

BUREAU V. S.

JAN 17 1956

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

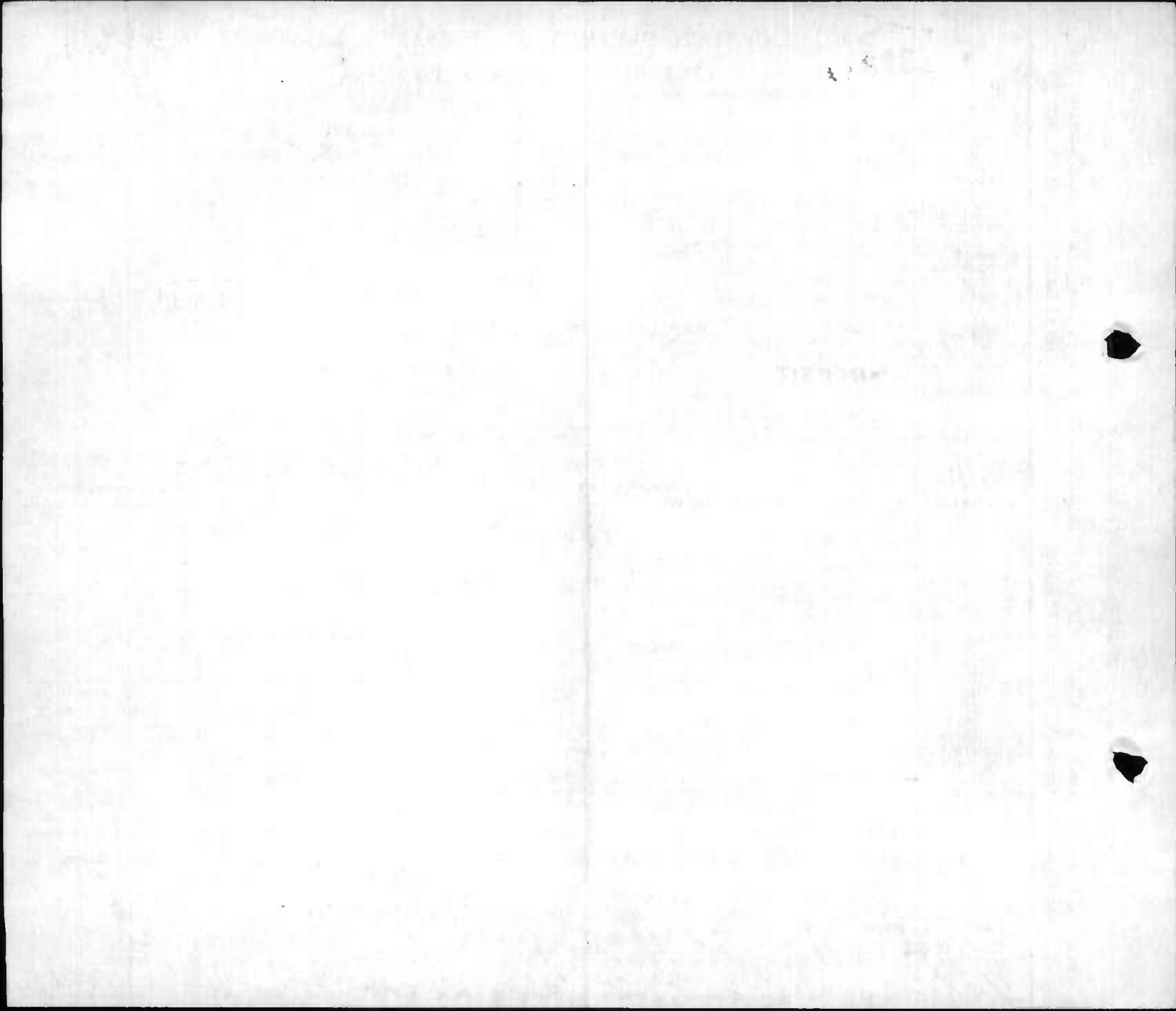
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313

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY	Baltimore	STATE	Maryland
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Catonsville	COUNTY	
TOWN	Catonsville	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN	Baltimore
HOSPITAL OR INSTITUTION OR STREET ADDRESS	SPRING GROVE STATE HOSPITAL	STREET ADDRESS (If rural give location)	4217 Woodmere Ave. -
3. NAME OF DECEASED:		4. DATE OF DEATH:	
(First)	(Middle)	(Last)	(Month) (Day) (Year)
Hyman		Levin	1-10-56 19
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
male	white	married	Jan; 1, 1871
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	9. AGE last birthday
GROCER		RETIRED	85 yrs.
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
Russia		unknown	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
Joseph Levin		Ida ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
unknown		unknown	
17. INFORMANT & ADDRESS:		18. MEDICAL CERTIFICATION	
Records of Spring Grove State Hospital		I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH	
422.1		(A) Arteriosclerotic cardiovascular disease	
IMMEDIATE CAUSE		DUE TO	
ANTECEDENT CAUSE (S)		(B) Generalized arteriosclerosis	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.		DUE TO	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		debility and senility	
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 7-22, 1953, to 1-10, 1956 that I last saw the deceased alive on 1-10, 1956, and that death occurred at 1:00p M, from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
Stella Wachler		1-10-56	
M. D. Catonsville 28, Md.		SPRING GROVE STATE HOSPITAL	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
Burial		Jan 11 1956	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Bnai Israel		Baltimore, Md.	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE	
1/11/56		A.W. Hedrick	
24. FUNERAL DIRECTOR		ADDRESS	
Sol. Harrison		1322 - 1124-26 W. North Ave	





314

CERTIFICATE OF DEATH

Reg. Dist. No.

33

1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town)  
TOWN **Owings Mills** LENGTH OF STAY (in this place)  
**1 1/2 yrs.**  
HOSPITAL OR INSTITUTION OR STREET ADDRESS **Rosewood State Tr. School**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Frederick**  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Frederick**  
STREET ADDRESS (If rural give location)  
**211 East 5th Street**

3. NAME OF DECEASED:

(First) **LeRoy** (Middle) **Loker** (Last) **Lipps**

4. DATE (Month) (Day) (Year) OF DEATH:

**1** **18** **19 56**

5. SEX:

**male**

6. COLOR OR RACE:

**white**

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

**single**

8. DATE OF BIRTH:

**4/18/03**

9. AGE last birthday:

**52 yrs.**

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

**---**

10B. KIND OF BUSINESS OR INDUSTRY:

**---**

11. BIRTHPLACE (State or foreign country):

**Maryland**

12. CITIZEN OF WHAT COUNTRY?

**U.S.A.**

13. FATHER'S NAME:

**Thomas Sylvester Lipps**

14. MOTHER'S MAIDEN NAME:

**Mamie Mariah Loker**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

**---**

16. SOCIAL SECURITY NO.

**---**

17. INFORMANT & ADDRESS:

**Rosewood Records**

18. MEDICAL CERTIFICATION

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

**491X**

IMMEDIATE CAUSE

(A) **Acute Broncho-Pneumonia**

ANTECEDENT CAUSE (S):

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

DUE TO

(B) DUE TO

(C)

II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

**Mental Deficiency**

INTERVAL BETWEEN ONSET AND DEATH

**1-2 days**

**since birth**

19A. DATE OF OPERATION:

19B. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

YES ☒ NO ☐

21A. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.

21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?

21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

**M.**

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from **1/16**, 19 **56** to **1/18**, 1956, that I last saw the deceased

alive on **1/18**, 19 **56**, and that death occurred at **8:35a** M, from the causes and on the date stated above.

SIGNATURE

**Harry B. Butler**

M. D.

ADDRESS

**Owings Mills Md Jan 56**

23. BURIAL, CREMATION, REMOVAL (SPECIFY) DATE THEREOF

**Burial**

**21 Jan 1956**

NAME OF CEMETERY OR CREMATORY

**Mount Olivet Cemetery**

LOCATION (City, town, or county) (State)

**Frederick, Maryland**

DATE REC'D BY LOCAL REGISTRAR

**Jan. 20, 1956**

REGISTRAR'S SIGNATURE

**Mary Eline**

24. FUNERAL DIRECTOR

**M. R. Etchison & Son, Frederick, Md.**

ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 23 1956

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

Item 2, Film G192 2-1-56 et

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Balto</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Balto</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>	LENGTH OF STAY (in this place) <u>2 1/2 yrs.</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Garrison</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor.</u>		STREET ADDRESS (If rural give location) <u>Garrison Forest School</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Mary Moncrieffe Livingston.</u>		4. DATE OF DEATH: (Month) (Day) (Year) <u>Jan. 26 19 56</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Single</u>	8. DATE OF BIRTH: <u>Feb 9. 1869</u>
		9. AGE last birthday: <u>86</u> yrs.	IF UNDER 1 YEAR: Months <u>11</u> Days <u>17</u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>School</u>	11. BIRTHPLACE (State or foreign country): <u>Ohio</u>
13. FATHER'S NAME: <u>Moncrieffe Livingston.</u>		14. MOTHER'S MAIDEN NAME: <u>Esther Harvey Dibblee.</u>	
15. WAS DECEASED EVER IN U.S. ARMY OR NAVY? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No.: <u></u>	
17. INFORMANT & ADDRESS: <u></u>			

18. MEDICAL CERTIFICATION				Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				
Immediate cause (a) <u>Cerebral hemorrhage</u>				<u>7 days.</u>
Antecedent causes (s) (b) <u>Blow on head</u>				<u>2 days</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>arterio-sclerosis</u>				<u>25 yrs.</u>
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.				
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT (Specify) <u>slight automobile</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	(CITY OR TOWN) <u>Lutherville</u>	(COUNTY) <u>Balto.</u>	(STATE) <u>Md.</u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>1/20/56 7:30 m.</u>	INJURY OCCURRED <u>While at Work</u>	HOW DID INJURY OCCUR? <u>Fell &amp; struck head.</u>		
22. I hereby certify that I attended the deceased from <u>Feb. 1932</u> to <u>Jan 26, 1956</u> that I last saw the deceased alive on <u>1/26, 1956</u> , and that death occurred at <u>2 P.M.</u> , from the causes and on the date stated above.				
SIGNATURE <u>Palmer F.C. Williams</u>		ADDRESS <u>M.D. Pikesville Md. 1/26/56.</u>		DATE SIGNED <u>1/26/56.</u>
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>Jan 28/56</u>	NAME OF CEMETERY OR CREMATORY <u>St Thomas</u>	LOCATION (City, town, county) <u>Garrison Forest</u>	(State) <u></u>
DATE REC'D BY LOCAL REGISTRAR <u>Jan. 27, 1956</u>	REGISTRAR'S SIGNATURE <u>Mabel C. Gray</u>	24. FUNERAL DIRECTOR <u>H.K. Jenkins</u>	ADDRESS <u>Sowle 4905 York Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 30 1956

BUREAU V. S.

316

## CERTIFICATE OF DEATH

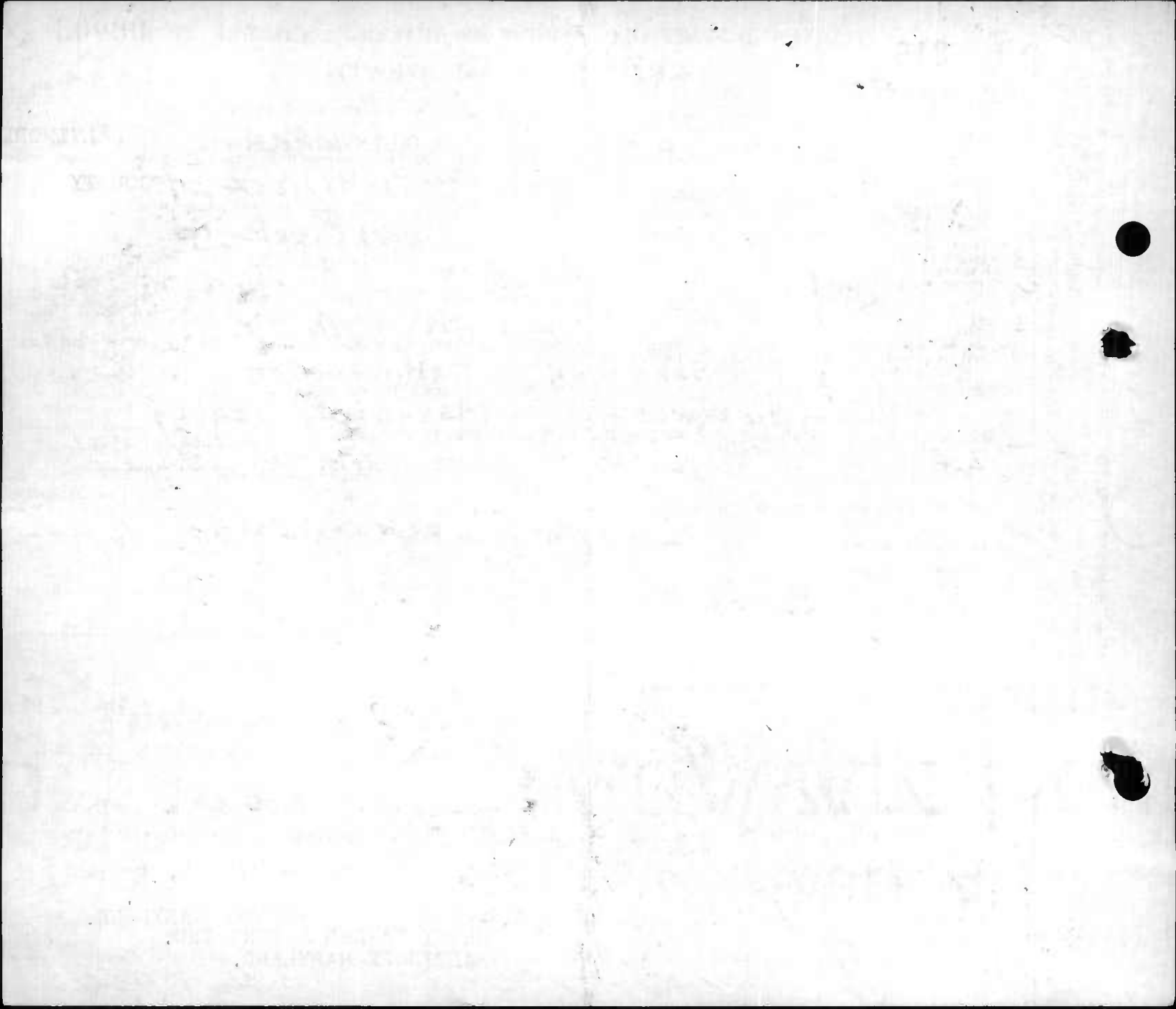
Reg. Dist. No. 38

Item 9, Film 92 2-3-56 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		COUNTY	
55 TOWN <u>Rural: Towson</u>				TOWN <u>Baltimore</u>		COUNTY <u>7</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Eudowood Sanatorium Towson 4, Maryland</u>				STREET ADDRESS (If rural give location) <u>3401 Ripple Rd.</u>			
3. NAME OF DECEASED: (Type or Print)				4. DATE OF DEATH: (Month) (Day) (Year)			
(First) (Middle) (Last) <u>Philip M. Lockwood</u>				DATE: <u>Jan 27</u> 19 <u>56</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH: <u>June 1, 1878</u>	
						9. AGE last birthday: <u>78</u> yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):				10b. KIND OF BUSINESS OR INDUSTRY: <u>Salesman</u>			
11. BIRTHPLACE (State or foreign country): <u>Baltimore City</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>			
13. FATHER'S NAME: <u>William Lockwood</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Bagley</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>				16. SOCIAL SECURITY No.: <u>212-03-7496</u>			
(If Yes, give war or dates of service)				17. INFORMANT & ADDRESS: <u>Personal History Hospital Records, Eudowood Sanatorium</u>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Immediate cause (a) <u>Pulmonary Tuberculosis.</u>							
Antecedent causes (s) (b) <u>2 yrs.</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>DUE TO</u>							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION:				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
m.							
22. I hereby certify that I attended the deceased from <u>2/19</u> , 19 <u>56</u> , to <u>1/27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/27</u> , 19 <u>56</u> , and that death occurred at <u>11:05 PM</u> from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>William B. Kues M.D.</u>				ADDRESS <u>Eudowood Sanatorium - Towson 4, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
BURIAL		<u>1/30/56</u>		WOODLAWN CEMETERY		WOODLAWN MARYLAND	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
				HENRY SANDER & SONS INC.		BALTIMORE MARYLAND	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





**INSTRUCTIONS**  
**1**  
**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

317

# CERTIFICATE OF DEATH

00304

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MIDDLESEX		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ruxton</u>				TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>90 Sorensen Nursing Home</u>				<u>1415 Linden Avenue</u>			
7912 Ruxway							
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Walter Bernard Logan</u>				<u>January 2, 1956</u>			
<b>5. SEX</b>		<b>6. COLOR OR RACE</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>	
<u>Male</u>		<u>White</u>		<u>Married</u>		<u>Aug. 17, 1875</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Clerk</u>		<u>U.S. Post Off.</u>		<u>Baltimore Md.</u>		<u>U.S.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Eugene Logan</u>				<u>Mary O'Neill</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No.</u>				<u>Walter G. Logan</u> <u>24 Morris La. Scarsdale N. Y.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b>				<u>Coronary thromboses</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>				<u>Hypertension</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>				<u>Myocarditis - chronic</u>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>decompensating</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>1-2-56</u>, to <u>1-2-56</u>, that I last saw the deceased alive on <u>1-2-56</u>, and that death occurred at <u>1-2-56</u> M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>James L. Saffell</u>				<u>1-3-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>24. REC'D BY REGISTRAR</b>			
<u>Burial</u>				<u>Mabel Gray</u>			
<b>DATE THEREOF</b>				<b>NAME OF CEMETERY OR CREMATORY</b>			
<u>1/3/56</u>				<u>New Cathedral Cem.</u>			
<b>LOCATION (City, town, or county)</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>Baltimore Md.</u>				<u>H.W. Jenkins and Sons Co.</u>			
<b>25. FUNERAL DIRECTOR'S ADDRESS</b>				<b>26. FUNERAL DIRECTOR'S ADDRESS</b>			
<u>4905 York Rd.</u>				<u>4905 York Rd.</u>			

# CERTIFICATE OF DEATH

100-000

DATE OF DEATH

DEATH CERTIFICATE NUMBER

MARYLAND

DEATH CERTIFICATE

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## CERTIFICATE OF DEATH

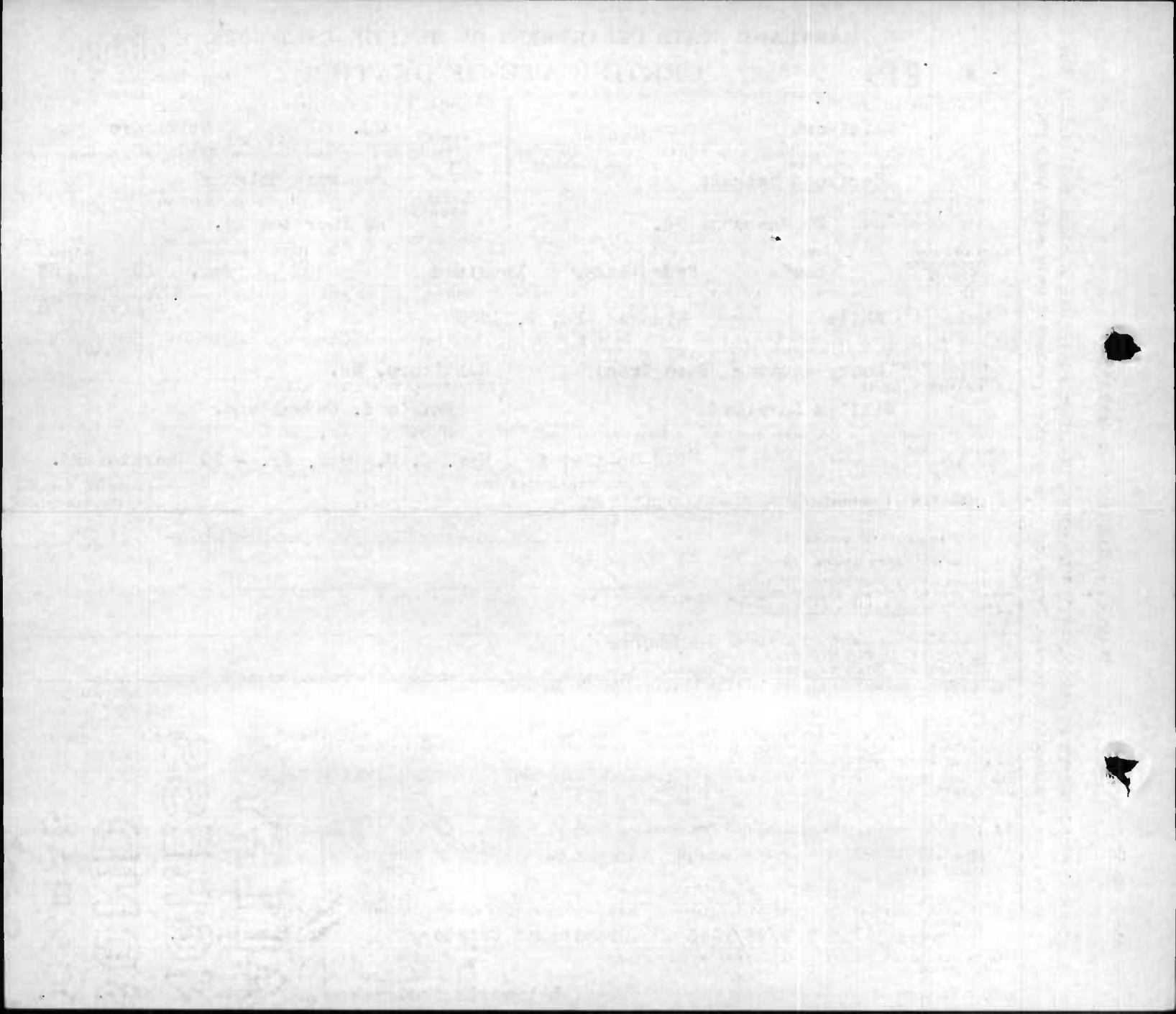
Reg. Dist. No.

318

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Hemwood Heights</b>				TOWN <b>Hemwood Heights</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS		20 Sheraton Rd.		STREET ADDRESS (If rural give location) 20 Sheraton Rd.			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <b>Lewis Cadwallader Loveland</b>				OF DEATH: <b>Jan. 19 19 56</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>Male</b>	<b>White</b>	<b>Widowed</b>	<b>May 5, 1889</b>	<b>66</b> yrs.	Months	Days	Hours
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<b>Money counter</b>				<b>Race Trace</b>		<b>Baltimore, Md.</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>William Loveland</b>				<b>Fannie B. Cadwallader</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>No</b>				<b>218-05-6397 A</b>		<b>Mrs. C. W. Rush, Sr. - 20 Sheraton Rd.</b>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A)						<b>Arteriosclerotic heart disease 2 yrs</b>	
ANTECEDENT CAUSE (S)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(B)							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <b>5 Aug, 1944</b> to <b>19 Jan, 1956</b> , that I last saw the deceased alive on <b>21 Dec, 1956</b> , and that death occurred at <b>2 P.M.</b> from the causes and on the date stated above.							
SIGNATURE				ADDRESS			
<b>Paul H. Rouse</b>				<b>Ricksville 8 md 19 Jan 56</b>			
M. D.				DATE SIGNED			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1/23/1956</b>		<b>Greenmount Cemetery</b>		<b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>1/23/56</b>		<b>A. M. Hedrick</b>		<b>Ellsworth Armacost</b>		<b>2600 Liberty Hgts. Ave.</b>	

MARGIN RESERVED FOR BINDING



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 TOM

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00306

319

## CERTIFICATE OF DEATH

Reg. Dist. No. <sup>38</sup>~~10~~

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>Towson</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Towson</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>20 Chesapeake Ave.</u>				STREET ADDRESS (If rural give location) <u>20 Chesapeake Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>JOSHUA</u>		(Middle) <u>LYNCH</u>		(Last)		(Month) (Day) (Year) <u>Jan. 5, 19 56</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>Nov. 8, 1875</u>	9. AGE last birthday <u>80</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Court House</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William R. Lynch</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Grace</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>219-03-0746</u>		17. INFORMANT & ADDRESS <u>Towson, Md.</u> <u>Mrs. M. G. Lynch-20 W. Chesapeake Ave.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
481X IMMEDIATE CAUSE (A) <u>Influenza + Bronchitis 4 days</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardiac Insufficiency</u>				5 yrs			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> el work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 3, 1956</u> to <u>Jan 3, 1956</u> that I last saw the deceased alive on <u>Jan 3, 1956</u> , and that death occurred at <u>2:30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Walter M. Hammett</u> M.D.				DATE SIGNED <u>Jan 5-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>Oaklawn Cem.</u>		LOCATION (City, town, or county) (State) <u>Balto. Co., Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Jan. 6, 1956</u>		REGISTRAR'S SIGNATURE <u>Mabel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. J. Tiekner &amp; Sons - Balto</u> ADDRESS <u>Md</u>			







MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. No. **00307**  
 No. **30**

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Balto</b>	MARYLAND	STATE <b>md</b>	COUNTY <b>Balto</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Catonsville</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town) TOWN <b>Baltimore City</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>5743 Edmonson on Ridgeway Manor</b>		STREET ADDRESS <b>5718 H rural, give location</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <b>Hellie</b>	(Middle) <b>do</b>	(Last) <b>Lynn</b>	(Month) <b>July</b> (Day) <b>13</b> (Year) <b>1956</b>
5. SEX: <b>7</b>	6. COLOR OR RACE: <b>w</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH: <b>Dec 23 1872</b>
9. AGE last birthday: <b>84</b> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		11. BIRTHPLACE (State or foreign country): <b>md</b>
13. FATHER'S NAME: <b>Marven H Alumba</b>		14. MOTHER'S MAIDEN NAME: <b>Emily Henson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <b>4579</b>	
17. INFORMANT & ADDRESS: <b>Mr. A. Weckert</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
Immediate cause (a) <b>Acute cardiac failure</b>	DUE TO	
Antecedent cause(s) (b) <b>Cardiovascular disease</b>	DUE TO	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <b>Senility</b>		

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
19a. DATE OF OPERATION:	19b. MAJOR FINDING OF OPERATION:	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)	21c. (City or town) (County) (State)
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <b>Dr. M. Kieffer</b>		1010 Keckrose	
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>		DATE THEREOF <b>1-16-56</b>	
NAME OF CEMETERY OR CREMATORY <b>Trinity Cem</b>		LOCATION (City, town, or county) (State) <b>Balto md</b>	
DATE REC'D BY LOCAL REG. <b>1-16-56</b>		24. FUNERAL DIRECTOR <b>Wm J. Choe &amp; Sons</b> ADDRESS <b>17, mt.</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

dear Sam

John Burleigh Jr

John  
off sps  
John Palmer

321

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>MARYLAND</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>OWINGS MILLS</u>		<u>65 yrs.</u>		TOWN <u>OWINGS MILLS</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>REISTERSTOWN ROAD</u>				STREET ADDRESS (If rural give location) <u>REISTERSTOWN- ROAD</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>MINNIE AGNES MAHON</u>				<u>Jan - 13 1956</u>			
5. SEX: <u>FEMALE</u>		6. COLOR OR RACE: <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widow</u>		8. DATE OF BIRTH: <u>Nov 23, 1896</u>	
9. AGE last birthday: <u>79</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>HOUSEWIFE</u>		11. BIRTHPLACE (State or foreign country): <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>JOEL REINECKER</u>				14. MOTHER'S MAIDEN NAME: <u>Carolyn Horwelle</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY No.: <u>no</u>		17. INFORMANT & ADDRESS: <u>Mrs. Frank Harnes Owings Mills</u>	

18. MEDICAL CERTIFICATION		Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
Immediate cause (a) <u>Coronary Thrombosis</u>		<u>1 day</u>
Antecedent causes (s) (b) <u>Chronic myocarditis</u>		<u>3 yrs.</u>
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Myocardial infarction</u>		<u>5 yrs.</u>

11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION:		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	
HOW DID INJURY OCCUR?		(CITY OR TOWN) (COUNTY) (STATE)	

22. I hereby certify that I attended the deceased from <u>JAN. 12, 1950</u> , to <u>JAN. 13, 1956</u> , that I last saw the deceased alive on <u>JAN. 12, 1956</u> , and that death occurred at <u>5:10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>James A. Miller M.D.</u>		DATE SIGNED <u>1/14/56</u>	
ADDRESS <u>Pikesville - Md.</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		NAME OF CEMETERY OR CREMATORY	
<u>Burial</u>		<u>Woodlawn</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 14, 1956</u>		REGISTRAR'S SIGNATURE <u>Frank H. Newell</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Pikesville - Md.</u>	

RECEIVED

JAN 27 1956

BUREAU V. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00309

322

## CERTIFICATE OF DEATH

Reg. Dist. No. 98 VC

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Balto.</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>Ruxton</b>		<b>9 Wks.</b>		TOWN <b>Balto.</b>		<b>3Y01-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>Sorensen Nursing Home 7912 Ruxton Dr. Ruxton Md.</b>				<b>4231 Flowerton Rd</b>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <b>Joseph</b> (Middle) <b>J.</b> (Last) <b>Maloney</b>				(Month) <b>Jan.</b> (Day) <b>9</b> (Year) <b>19 56</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>M.</b>	<b>W.</b>	<b>Widower</b>	<b>Jun. 8, 1883</b>	<b>72</b> yrs.	Months <b>8</b>	Days <b>1</b>	Hours <b></b> Min. <b></b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>Retired</b>		<b>Bartender</b>		<b>Pa.</b>		<b>U.S.A.</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<b>John Maloney</b>				<b>Bridgit ( )</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
(If Yes, give war or dates of service)		<b>220-03-6120</b>		<b>Mrs Bartus E. Wigley, 4231 Flowerton</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
441X IMMEDIATE CAUSE (A) <b>Myocarditis chronic with failure</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Myocardial hypertrophy</b>						<b>2 months</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>Hypertension arterial malignant</b>						<b>5 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Arteriosclerosis general</b>						<b>5 years</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY?	
<b>none</b>		<b>no operation</b>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
				<b>no injury</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>no injury</b>		<b>M.</b>		<b>no injury</b>			
22. I hereby certify that I attended the deceased from <b>Oct 27</b> , 19 <b>55</b> , to <b>Jan. 9th</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>Jan 5</b> , 19 <b>56</b> , and that death occurred at <b>6:30</b> M, from the causes and on the date stated above.							
SIGNATURE <b>James Graham Martin</b>				ADDRESS (Street, city, town, state) <b>516 Cathedral Street Balto. Md.</b>			
DATE <b>Jan 10, 1956</b>				DATE SIGNED <b>Jan 10, 1956</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Jan. 12/56</b>		<b>New Cathedral Cemetery</b>		<b>Balto. Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <b>1/13/56</b>		<b>Maable C. Gray</b>		<b>Harry H. Wigley</b>		<b>4101 EDMONDSON AVE</b>	

# CERTIFICATE OF DEATH

323

Reg. Form No. 1

1. NAME OF DECEASED (Print Name)

2. PLACE OF DEATH

3. SEX (Male or Female)

4. AGE (Years)

5. OCCUPATION

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF BIRTH

10. MARRIAGE

11. EDUCATION

12. PREVIOUS ILLNESS

13. MEDICAL HISTORY

14. SOCIAL HISTORY

15. SIGNATURE OF DECEASED

16. SIGNATURE OF WITNESSES

17. SIGNATURE OF PHYSICIAN

18. SIGNATURE OF CORONER

19. SIGNATURE OF JURY

20. SIGNATURE OF JUDGE

21. SIGNATURE OF CLERK

22. SIGNATURE OF REGISTRAR

23. SIGNATURE OF NOTARY

24. SIGNATURE OF SHERIFF

25. SIGNATURE OF DEPUTY SHERIFF

26. SIGNATURE OF CONSTABLE

27. SIGNATURE OF JAILER

28. SIGNATURE OF WARDEN

29. SIGNATURE OF CHIEF OF POLICE

30. SIGNATURE OF DETECTIVE

31. SIGNATURE OF INSPECTOR

32. SIGNATURE OF SUPERVISOR

33. SIGNATURE OF AGENT

34. SIGNATURE OF CLERK

35. SIGNATURE OF REGISTRAR

36. SIGNATURE OF NOTARY

37. SIGNATURE OF SHERIFF

38. SIGNATURE OF DEPUTY SHERIFF

39. SIGNATURE OF CONSTABLE

40. SIGNATURE OF JAILER

41. SIGNATURE OF WARDEN

42. SIGNATURE OF CHIEF OF POLICE

43. SIGNATURE OF DETECTIVE

44. SIGNATURE OF INSPECTOR

45. SIGNATURE OF SUPERVISOR

46. SIGNATURE OF AGENT

47. SIGNATURE OF CLERK

48. SIGNATURE OF REGISTRAR

49. SIGNATURE OF NOTARY

50. SIGNATURE OF SHERIFF

51. SIGNATURE OF DEPUTY SHERIFF

52. SIGNATURE OF CONSTABLE

53. SIGNATURE OF JAILER

54. SIGNATURE OF WARDEN

55. SIGNATURE OF CHIEF OF POLICE

56. SIGNATURE OF DETECTIVE

57. SIGNATURE OF INSPECTOR

58. SIGNATURE OF SUPERVISOR

59. SIGNATURE OF AGENT

60. SIGNATURE OF CLERK

61. SIGNATURE OF REGISTRAR

62. SIGNATURE OF NOTARY

63. SIGNATURE OF SHERIFF

64. SIGNATURE OF DEPUTY SHERIFF

65. SIGNATURE OF CONSTABLE

66. SIGNATURE OF JAILER

67. SIGNATURE OF WARDEN

68. SIGNATURE OF CHIEF OF POLICE

69. SIGNATURE OF DETECTIVE

70. SIGNATURE OF INSPECTOR

71. SIGNATURE OF SUPERVISOR

72. SIGNATURE OF AGENT

73. SIGNATURE OF CLERK

74. SIGNATURE OF REGISTRAR

75. SIGNATURE OF NOTARY

76. SIGNATURE OF SHERIFF

77. SIGNATURE OF DEPUTY SHERIFF

78. SIGNATURE OF CONSTABLE

79. SIGNATURE OF JAILER

80. SIGNATURE OF WARDEN

81. SIGNATURE OF CHIEF OF POLICE

82. SIGNATURE OF DETECTIVE

83. SIGNATURE OF INSPECTOR

84. SIGNATURE OF SUPERVISOR

85. SIGNATURE OF AGENT

86. SIGNATURE OF CLERK

87. SIGNATURE OF REGISTRAR

88. SIGNATURE OF NOTARY

89. SIGNATURE OF SHERIFF

90. SIGNATURE OF DEPUTY SHERIFF

91. SIGNATURE OF CONSTABLE

92. SIGNATURE OF JAILER

93. SIGNATURE OF WARDEN

94. SIGNATURE OF CHIEF OF POLICE

95. SIGNATURE OF DETECTIVE

96. SIGNATURE OF INSPECTOR

97. SIGNATURE OF SUPERVISOR

98. SIGNATURE OF AGENT

99. SIGNATURE OF CLERK

100. SIGNATURE OF REGISTRAR

101. SIGNATURE OF NOTARY

102. SIGNATURE OF SHERIFF

103. SIGNATURE OF DEPUTY SHERIFF

104. SIGNATURE OF CONSTABLE

105. SIGNATURE OF JAILER

106. SIGNATURE OF WARDEN

107. SIGNATURE OF CHIEF OF POLICE

108. SIGNATURE OF DETECTIVE

109. SIGNATURE OF INSPECTOR

110. SIGNATURE OF SUPERVISOR

111. SIGNATURE OF AGENT

112. SIGNATURE OF CLERK

113. SIGNATURE OF REGISTRAR

114. SIGNATURE OF NOTARY

115. SIGNATURE OF SHERIFF

116. SIGNATURE OF DEPUTY SHERIFF

117. SIGNATURE OF CONSTABLE

118. SIGNATURE OF JAILER

119. SIGNATURE OF WARDEN

120. SIGNATURE OF CHIEF OF POLICE

121. SIGNATURE OF DETECTIVE

122. SIGNATURE OF INSPECTOR

123. SIGNATURE OF SUPERVISOR

124. SIGNATURE OF AGENT

125. SIGNATURE OF CLERK

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323

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Allegheny</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>52 Catonsville</u>		<u>17 mos.</u>		TOWN <u>Cumberland</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1600 Idlewilde Ave.</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Ethel Fisher Mason</u>				<u>Jan. 18, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>F</u>	<u>W</u>	<u>Married</u>	<u>Aug. 20, 1937</u>	<u>68</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housekeeper</u>		<u>Home</u>		<u>W. Va.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Sanford F. Fisher</u>				<u>Florence Miller</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>-</u>		<u>---</u>		<u>Mrs. P. W. Peters 1600 Idlewilde</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
4221 IMMEDIATE CAUSE (A)				<u>MYOCARDITIS CHRONIC.</u>			
ANTECEDENT CAUSE(S) DUE TO				<u>CEREBRAL HEMORRHAGE.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST DUE TO (C)				<u>ARTERIOSCLEROSIS.....</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				<u>2-3 years</u>			
				<u>6 MONTHS</u>			
				<u>years</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?			
<u>0</u>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, lecture, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<u>0</u>		<u>0</u>		<u>0</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<u>0</u>		<u>0</u>					
22. I hereby certify that I attended the deceased from <u>JULY, 26, 1954</u> , to <u>Jan. 18, 1956</u> , that I last saw the deceased alive on <u>JAN. 18, 1956</u> , and that death occurred at <u>10:08 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city, town, state) <u>Catonsville Md.</u>			
				DATE SIGNED <u>Jan. 20, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>1-21-56</u>		<u>Lorraine Park</u>		<u>Woodlawn Md.</u>	
24. RECEIVED BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan. 27, 1956</u>		<u>V. E. Harry</u>		<u>Forley Funeral Home - Catonsville, Md.</u>			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



## MARYLAND STATE DEPARTMENT OF HEALTH

00311

2411 N. Charles Street, Baltimore

324

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 8, Film G193 2-27-56 et

1. PLACE OF DEATH COUNTY <b>Baltimore</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>Maryland</b> COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Catonsville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>61 Winters Lane</b>		STREET ADDRESS (If rural, give location) <b>61 Winters Lane</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>Louise</b>	(Middle) <b>Matthews</b>	(Last)
6. SEX <b>Female</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>1915 2-14-1914</b>	9. AGE last birthday <b>40</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>Jefferson Berbour</b>		14. MOTHER'S MAIDEN NAME <b>Alice Step</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <b>Mr. Raymond Matthews Winters La.</b>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

42011 Immediate cause

(a) **Myocardial infarct**Antecedent cause(s)  
Disease or conditions, if any, giving rise to the above cause stating the underlying cause last(b) **Hypertensive Cardiac Disease**

INTERVAL BETWEEN ONSET AND DEATH

**Shows****10-15 years**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

**None**

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **Feb**, 19**55**, to **Jan**, 19**56**, that I last saw the deceasedalive on **11 Jan**, 19**56**, and that death occurred at **11 P** m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

**C. R. Sanitem, M.D.** **305A Winters Ave, Baltimore 28 Md.** **11 Jan 56**

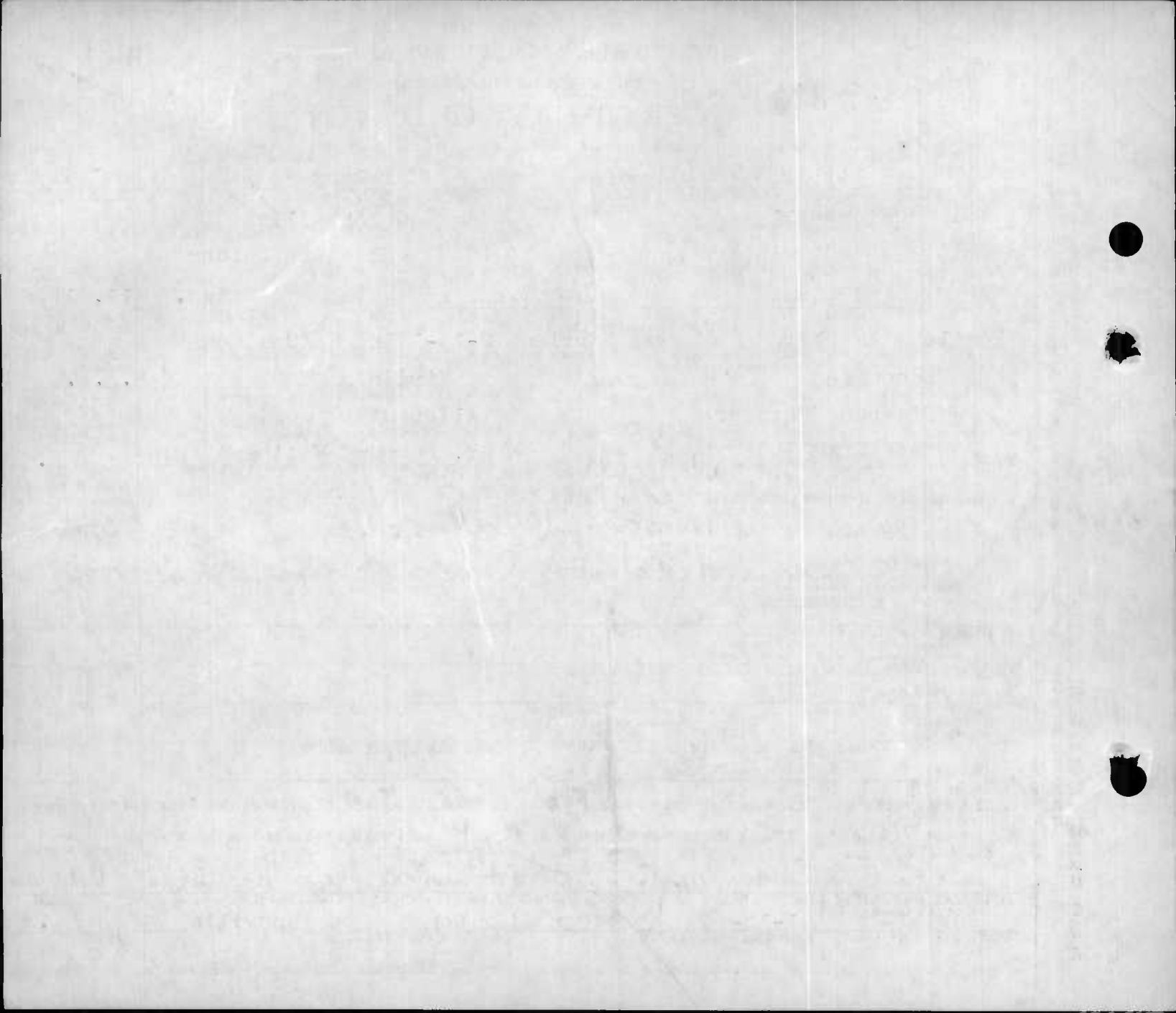
23. BURIAL, CREMATION REMOVAL (Specify) <b>Burial</b>	DATE THEREOF <b>1-15-56</b>	NAME OF CEMETERY OR CREMATORY <b>Western Star Cem.</b>	LOCATION (City, town, or county) <b>Catonsville</b>	(State) <b>Md.</b>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE <b>H. W. Hedrick</b>	FUNDAL DIRECTOR <b>Mr. James C. Hensley</b>		

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00312

325

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTO-</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>SPARROWS POINT</u>		<u>57</u>		TOWN <u>SPARROWS POINT (19)</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>617 E ST.</u>		<u>ST.</u>		<u>617 E ST.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JOHN</u> (Middle) <u>ANDREW M</u> (Last) <u>MC FADDEN</u>				(Month) <u>1-</u> (Day) <u>20-</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M.</u>	<u>W</u>	<u>MARRIED</u>	<u>JULY 29, 1869</u>	<u>86</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>MACHINIST</u>		<u>STEEL MFGR.</u>		<u>PENNA.</u>		<u>USA</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>WM MC FADDEN</u>				<u>ISABELLA (?)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>NO</u>		<u>214-10-0096</u>		<u>MARY MCH. MCFADDEN - SAME</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>5 days.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerosis</u>						<u>15 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 1, 19 56</u> , to <u>Jan 20, 19 56</u> , that I last saw the deceased alive on <u>Jan 19, 19 56</u> , and that death occurred at <u>9A</u> M, from the causes and on the date stated above.							
SIGNATURE <u>John Andrew McFadden</u>				ADDRESS (Street, city, town, state) <u>520 1st</u>		DATE SIGNED <u>1-20-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1/23/56</u>		<u>CATHEDRAL</u>		<u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>1-23/56</u>		<u>Dawson L. Foster</u>		<u>W. Parker Bradley, President, Md.</u>			

10315

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

10315

Section 100

1. NAME OF DECEASED

MARYLAND

1000000000

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. MANNER OF DEATH

5. DATE OF DEATH

6. TIME OF DEATH

7. SEX

8. AGE

9. OCCUPATION

10. EDUCATION

11. RELIGION

12. MARITAL STATUS

13. SOCIAL CLASS

14. RACE

15. ETHNICITY

16. SEX

17. AGE

18. OCCUPATION

19. EDUCATION

20. RELIGION

10. MEDICAL CERTIFICATION

11. MEDICAL CERTIFICATION

12. MEDICAL CERTIFICATION

13. MEDICAL CERTIFICATION

14. MEDICAL CERTIFICATION

15. MEDICAL CERTIFICATION

16. MEDICAL CERTIFICATION

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22. MEDICAL CERTIFICATION

BUREAU V. S.

JAN 25 1956

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RECEIVED



326

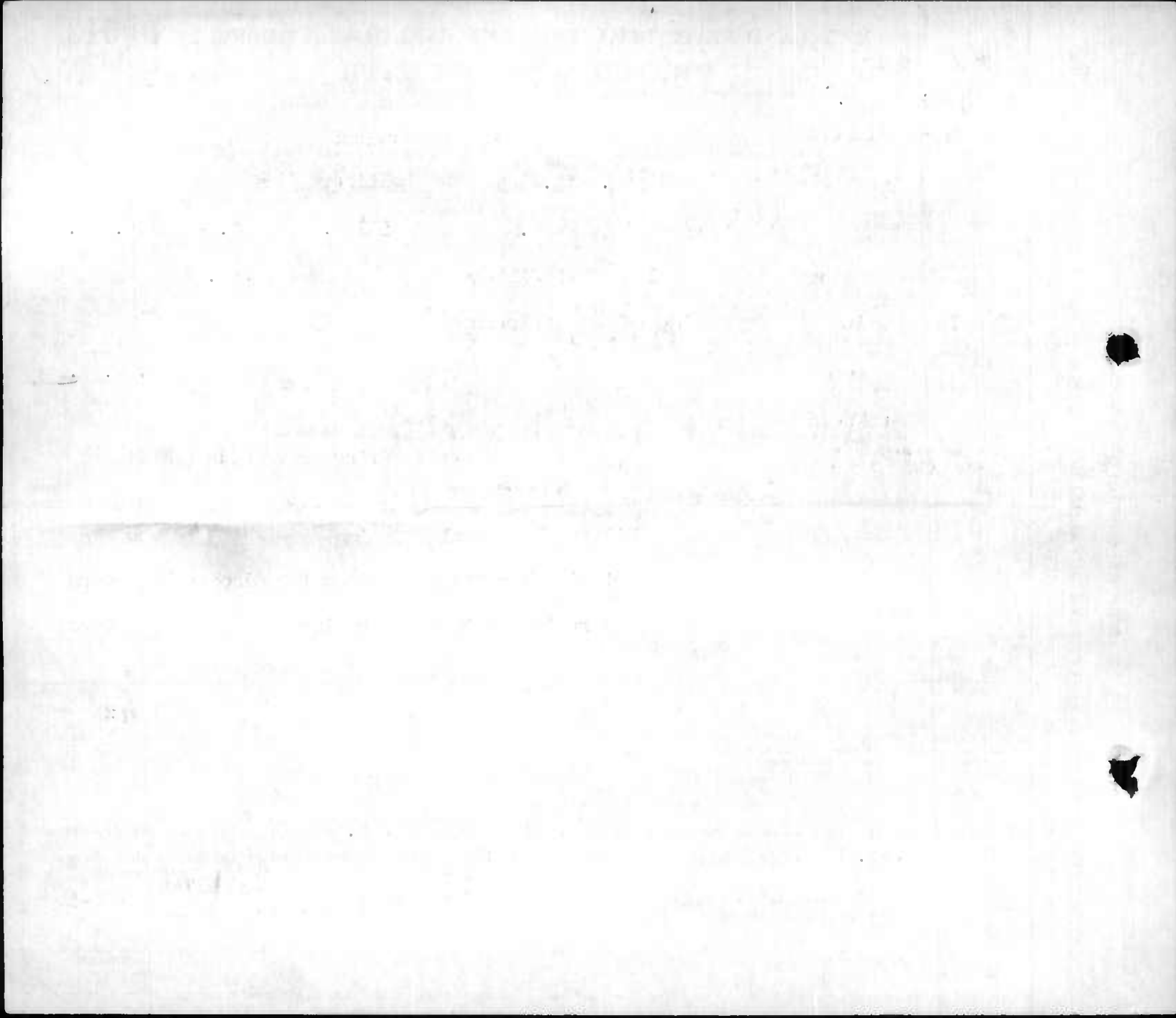
## CERTIFICATE OF DEATH

Reg. Dist. No. 30...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>57 TOWN Catonsville</u>		LENGTH OF STAY (in this place) <u>18yrs. 1mth. 23dys</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore City</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp.</u>				STREET ADDRESS (If rural give location) <u>531 W. 27th St. - Balto. Md. ✓</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Anna (NANNIE) Bell McJilton</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 26</u> 19 <u>56</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>widowed</u>	8. DATE OF BIRTH: <u>unknown</u>	9. AGE last birthday <u>83</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>none</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME: <u>unknown</u>				14. MOTHER'S MAIDEN NAME: <u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>unknown</u>		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bilateral pleural effusion</u>						<u>weeks</u>	
ANTECEDENT CAUSE (B) <u>Arteriosclerotic cardiovascular disease</u>						<u>years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Generalized arteriosclerosis</u>						<u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>53</u> , to <u>Jan. 26, 1956</u> , that I last saw the deceased alive on <u>Jan. 26, 1956</u> , and that death occurred at <u>12:15M</u> , from the causes and on the date stated above.							
SIGNATURE <u>Harold Edwards MD</u>		ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>1-26-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>Jan 28 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Green Mount</u>		LOCATION (City, town, or county) (State) <u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-24-56</u>		REGISTRAR'S SIGNATURE <u>D. W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Green Mount</u>		ADDRESS <u>Baltimore</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00314

327

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>N. Y.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Timonium Md.</u>				TOWN <u>Yonkers N. Y.</u>		<u>69X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>York Rd. Timonium Md.</u>				STREET ADDRESS (If rural give location) <u>24 Seymour St.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Annie Mc Millan</u>				<u>1 31 19 56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED,</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>2-15-1878</u>	<u>77</u> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<u>Housewife</u>					<u>Edenborough Scotland</u>		<u>U. S. A.</u>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>John Docherty</u>				<u>Ellen Cordana</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or detas of service)			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>		
<u>No</u>			<u>None</u>		<u>Annie T. Mc Millan</u> <u>Same</u>		
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>15. MEDICAL CERTIFICATION</b>			
<u>153X</u>				<u>IMMEDIATE CAUSE (A) <u>CARCINOMA OF COLON</u></u>			
<u>ANTECEDENT CAUSE(S) DUE TO</u>							
<u>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</u>				<u>DUE TO</u>			
				<u>(C)</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>				<u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u>			
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b>		<b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not white at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>SEPT.</u>, 19<u>55</u>, to <u>JAN.</u>, 19<u>56</u>, that I last saw the deceased alive on <u>JAN. 31</u>, 19<u>56</u>, and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>William A. Piesing</u> M.D.				<u>Timonium</u> <u>2-1-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<u>Burial Removal</u>		<u>2-1-56</u>		<u>Mt. Hope Cemetery</u>		<u>Hastings on the Hudson</u> <u>N.Y.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>FEB 1 1956</u>		<u>Anna Mac Ray</u>		<u>Henry W. Jenkins and Sons Co.</u>			
<b>DATE</b>				<b>ADDRESS</b>			
				<u>1905 York Road, Baltimore 12, Md.</u>			



CERTIFICATE OF DEATH

Reg. Dist. No.....

207

1. PLACE OF DEATH:

COUNTY **Baltimore** MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) **Lansdowne** LENGTH OF STAY (in this place)  
HOSPITAL OR INSTITUTION OR STREET ADDRESS **117 3 rd Ave**

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Md.** COUNTY **Baltimore**  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN **Lansdowne** 51  
STREET ADDRESS (If rural, give location) **117 Third Ave** 1

3. NAME OF DECEASED: (First) (Middle) (Last)  
(Type or Print) **August George Miller Sr.**

4. DATE OF DEATH: (Month) (Day) (Year)  
**Jan 10, 1956** 19

5. SEX: **male** 6. COLOR OR RACE: **white** 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **married** 8. DATE OF BIRTH: **Sept. 11, 1896** 9. AGE last birthday: **59** yrs. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Cleark** 10b. KIND OF BUSINESS OR INDUSTRY: **A & P Tea Co.** 11. BIRTHPLACE (State or foreign country): **Baltimore** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME:

**James A. Miller**

14. MOTHER'S MAIDEN NAME:

**Emma Gilster**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **yes world war**

16. SOCIAL SECURITY No.: **1 213-10-5700** 17. INFORMANT & ADDRESS: **Velma L. Miller 117 Third Ave.**

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

443 x  
Immediate cause

(a) **Hypertensive Cardiovascular Disease**  
DUE TO

INTERVAL BETWEEN ONSET AND DEATH

**5 yrs**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) **Essential Hypertension**  
DUE TO

**7 yrs**

(c)

II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT (Specify) PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)  
SUICIDE  
HOMICIDE  
INJURY

TIME (Month) (Day) (Year) (Hour) OF INJURY INJURY OCCURRED While at Not while work at work  
M. work at work

HOW DID INJURY OCCUR?

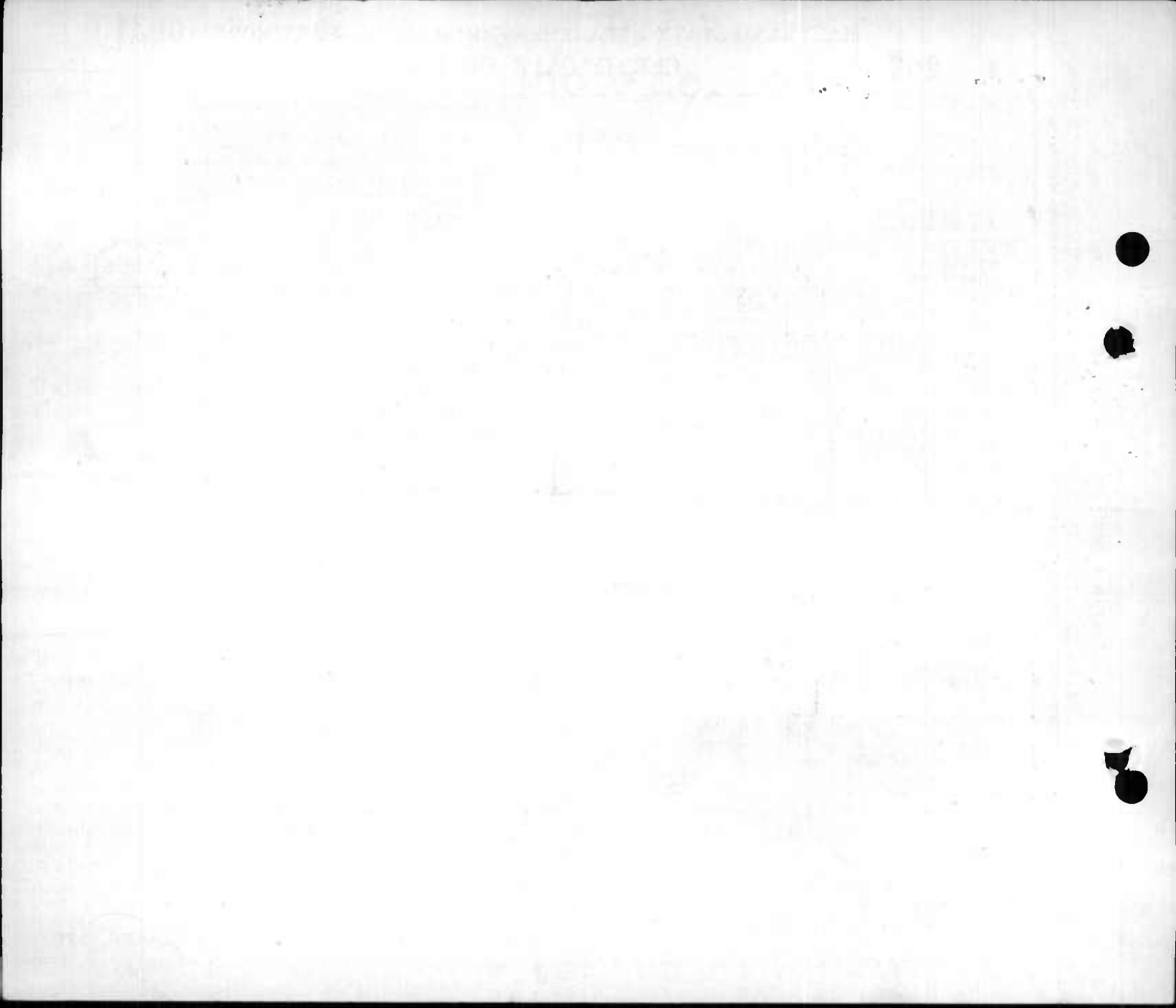
22. I hereby certify that I attended the deceased from **Oct. 1, 1951**, to **Jan. 10, 1956**, that I last saw the deceased alive on **Nov. 28, 1955**, and that death occurred at **9:15 P.m.**, from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED  
**C. Arthur Rossberg M.D. 2436 Washington Blvd. Balto-30 Ind. 1/1/56**

23. BURIAL, CREMATION REMOVAL (Specify): DATE THEREOF NAME OF CEMETERY OR CREMATORY LOCATION (City, town, or county) (State)  
**Burial 1-13-56 Baltimore National Baltimore, Md.**

DATE REC'D BY LOCAL REG. REGISTRAR'S SIGNATURE 24. FUNERAL DIRECTOR ADDRESS  
**1/12/56 J. W. Hedrich Howard H. Hubbard, 4107 Wilkens Ave**

MARGIN RESERVED FOR BINDING





328

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Prince George</u>
CITY (If outside corporate limits, write RURAL and give nearest town) <u>522 TOWN Catonsville</u>	LENGTH OF STAY (in this place) <u>4 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>OR TOWN College Park</u> <u>1614 2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location) <u>8908 Baltimore Avenue</u>	
3. NAME OF DECEASED:		4. DATE (Month) (Day) (Year) OF DEATH:	
(First) <u>Florence</u>	(Middle) <u>Miller</u>	(Last) <u>19 56</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>5-9-1885</u>
9. AGE last birthday <u>70</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Robert Shoemaker</u>		14. MOTHER'S MAIDEN NAME: <u>Louise Johnson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT & ADDRESS: <u>Records Spring Grove State Hospital</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>Terminal bronchopneumonia</u>			<u>4 days</u>
ANTECEDENT CAUSE (S) (B) <u>Cerebrovascular hemiplegic accident</u>			<u>5 years</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1-13-1956</u> to <u>1-17-1956</u> that I last saw the deceased alive on <u>1-17-1956</u> , and that death occurred at <u>6:10 P.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>Stella Washler</u>		ADDRESS <u>Spring Grove State Hospital</u> DATE SIGNED <u>1-18-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Transportation</u>		DATE THEREOF <u>1/18/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Elizabethton</u>		LOCATION (City, town, or county) (State) <u>Tennessee</u>	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 18, 1956</u>		REGISTRAR'S SIGNATURE <u>T.E. Harry</u>	
24. FUNERAL DIRECTOR <u>F. Gasche and Galt</u>		ADDRESS <u>28 Maryland</u>	

RECEIVED

JAN 25 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2, Film G192 2-21-56 et

## CERTIFICATE OF DEATH

Reg. Dist. No.

00317

30

1. PLACE OF DEATH: <i>Spring Grove State Hospital</i> Balto., <i>Maryland</i> COUNTY <i>MARYLAND</i>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <i>Md.</i> COUNTY <i>Balto.</i> CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <i>Baltimore 28, Md.</i> Balto. 3V01-4	
CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <i>Baltimore 28, Md.</i>		CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN <i>Baltimore 28, Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Spring Grove State Hospital</i>		STREET ADDRESS (If rural give location) <i>334 S. Stricker St., Balto. 29</i>	
3. NAME OF DECEASED: (First) <i>Henry</i> (Middle) <i>William</i> (Last) <i>Miller</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>1. 21. 1956</i>	
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify):	8. DATE OF BIRTH: <i>1872-JUNE 10 1871</i>
9. AGE last birthday <i>84</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	11. IF UNDER 24 HRS.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Retired engineer</i>		10B. KIND OF BUSINESS OR INDUSTRY: <i>B &amp; O R.R.</i>	
11. BIRTHPLACE (State or foreign country): <i>Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>John Miller</i>		14. MOTHER'S MAIDEN NAME: <i>Margaret Elizabeth KLAUS MEYER</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) (If Yes, give war or dates of service) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT & ADDRESS: <i>GERTRUDE V. MILLER 334 S. STRICKER ST</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>420.0</i>			
ANTECEDENT CAUSE (S) <i>Arteriosclerotic Heart Disease</i>			<i>Several</i>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			<i>General arteriosclerosis</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>Prothrombotic condition, dehydration.</i>			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	21C. WHERE DID (City or town) INJURY OCCUR?	(County) (State)
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>1/11</i> , 1956, to <i>1-21</i> , 1956, that I last saw the deceased alive on <i>1-21</i> , 1956, and that death occurred at <i>7:25 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Stella Wachler</i>		ADDRESS <i>M.D. Spring Grove State Hospital</i> DATE SIGNED <i>1/21/56</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>	DATE THEREOF <i>JAN 24-1956</i>	NAME OF CEMETERY OR CREMATORY <i>NEW CATHEDRAL</i>	LOCATION (City, town, or county) (State) <i>BALTO MD</i>
DATE REC'D BY LOCAL REGISTRAR <i>1/23/56</i>	REGISTRAR'S SIGNATURE <i>V. W. Hedrich</i>	24. FUNERAL DIRECTOR <i>JOHN B. M. Walters</i> ADDRESS <i>Stricker St.</i>	



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS MISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00318

330

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>BALTIMORE</u>		STATE <u>MARYLAND</u>		COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>TOWSON</u>		<u>3 YRS</u>		TOWN <u>TOWSON</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>40 DUNKIRK RD.</u>				STREET ADDRESS (If rural give location) <u>40 DUNKIRK RD - 12</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JAMES</u> (Middle) <u>HENRY</u> (Last) <u>MITCHELL</u>				(Month) <u>1</u> (Day) <u>31</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JULY 25, 1887</u>	9. AGE last birthday <u>68</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECRETARY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>BUILDING + LOAN</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>JAMES H. MITCHELL</u>				14. MOTHER'S MAIDEN NAME <u>EMMA KNAUSS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>213-12-7681</u>		17. INFORMANT & ADDRESS <u>JAMES H. MITCHELL JR 40 DUNKIRK RD</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>1 hour</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Atherosclerosis of Pericardium</u>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 31, 1956</u> to <u>Jan 31, 1956</u> , that I last saw the deceased alive on <u>Jan 31, 1956</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William L. Helbrecht</u>				ADDRESS (Street, city, town, state) <u>5006 Roland Ave. BALTO. MD.</u>		DATE SIGNED <u>1/31/56</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>2-3-56</u>		NAME OF CEMETERY OR CREMATORY <u>LORRAINE PARK CEM</u>		LOCATION (City, town, or county) <u>BALTO.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Markel Gray</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>St. John's Am Co.</u>		ADDRESS <u>4905 YORK RD.</u>	
DATE <u>FEB 1 1956</u>							

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40 Bunkers Rd.

Page 2

Henry Mitchell

W. H. W.

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Y: 1973-10-31

1942-1943

JAMES H. MITCHELL

Enoch K. 1912

513-15-5681 JAMES H. HARRIS

5

BUREAU V. S.

FEB 1 1964

RECEIVED



331

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00319

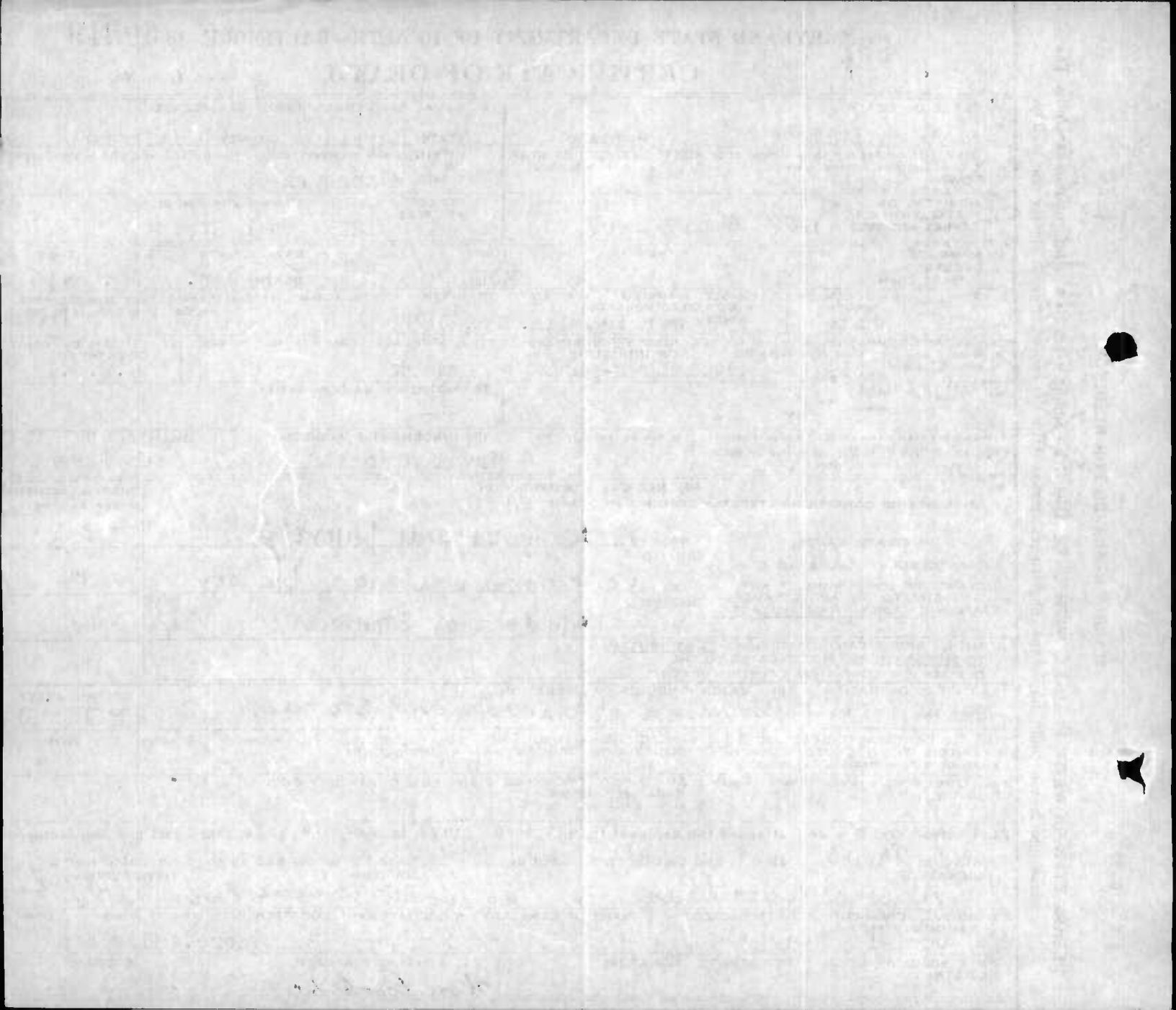
## CERTIFICATE OF DEATH

Reg. Dist. No. 43

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Raspeburg</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Raspeburg</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1227 64th Street</u>		STREET ADDRESS (If rural give location) <u>1227 64th Street</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>BRUNO</u> <u>MOLL</u>		OF DEATH: <u>Jan.</u> <u>17,</u> <u>1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>Jan. 26, 1893</u>
9. AGE last birthday <u>62</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk - Adv. News-Post</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Denmark</u>	
11. BIRTHPLACE (State or foreign country): <u>Denmark</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>--- Moll</u>		14. MOTHER'S MAIDEN NAME: <u>---</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>	
17. INFORMANT & ADDRESS: <u>Raspeburg</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Acute myocardial failure</u>		<u>2 days</u>	
ANTECEDENT CAUSE (S) (B) <u>Carcinoma of urinary bladder</u>		<u>6 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Carcinoma of Stomach</u>		<u>6 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>Oct 14, 1956</u>		19B. MAJOR FINDINGS OF OPERATION: <u>Carcinoma of bladder and Stomach</u>	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Oct 10</u> , 19 <u>55</u> , to <u>Jan. 16</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 16</u> , 19 <u>56</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.			
SIGNATURE <u>Benz P. Abes House</u>		ADDRESS <u>M. D. 100 W monument St</u> DATE SIGNED <u>1/18/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/20/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/18/56</u>		REGISTRAR'S SIGNATURE <u>Wm. Cook, Inc.</u>	
24. FUNERAL DIRECTOR <u>Wm. Cook, Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	



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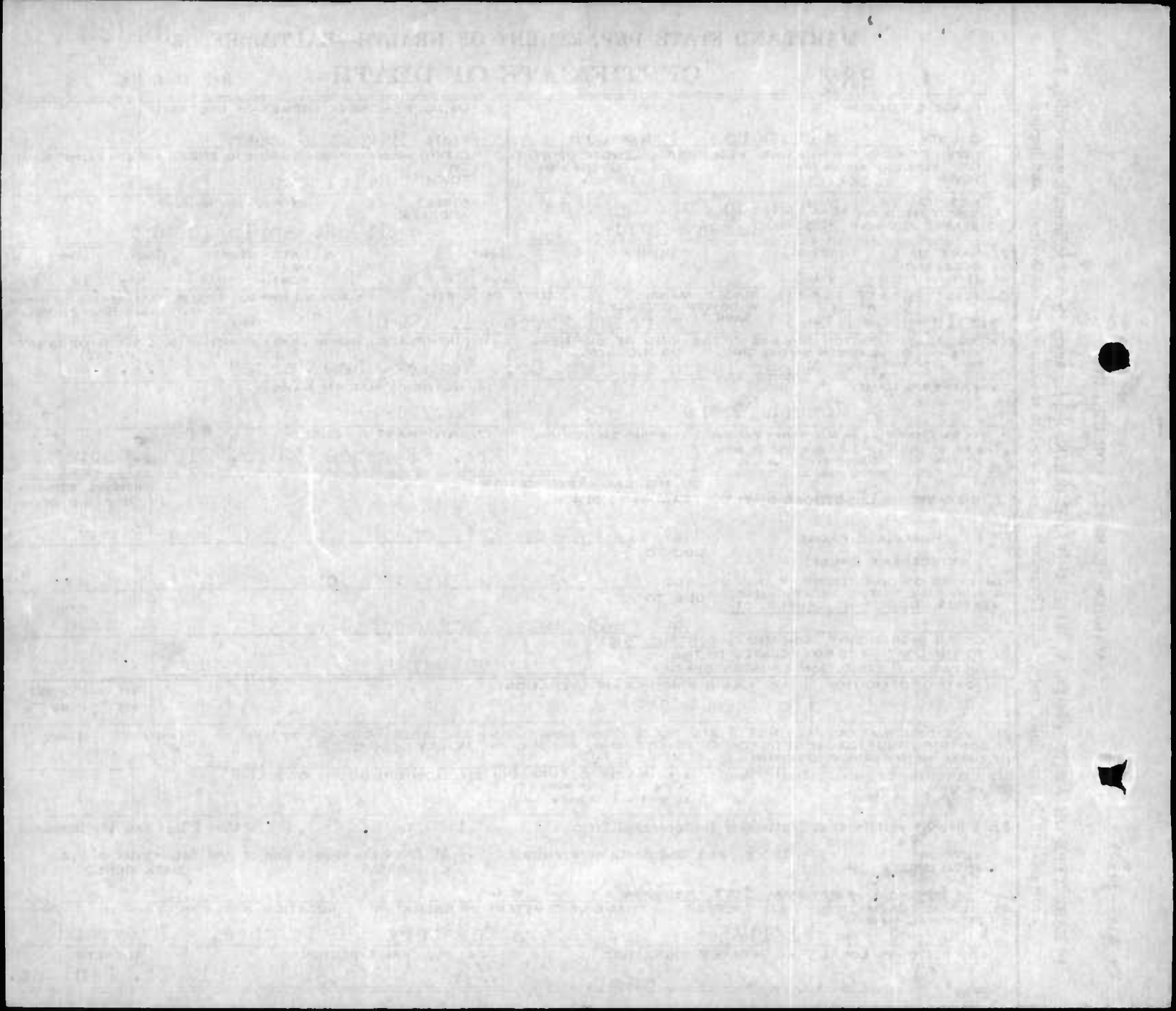
CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Ruxton</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorrenson Nursing Home</u>				STREET ADDRESS (If rural give location) <u>219 S. Spring Court</u>			
3. NAME OF DECEASED: (Type or Print) <u>JOHN</u>		(First) (Middle) (Last) <u>MOORE</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 8, 1956</u>			
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>March 21, 1901</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months <u>9</u> Days <u>18</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Box Maker</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Assu Canning Co.</u>		11. BIRTHPLACE (State or foreign country): <u>Newark, New Jersey</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Joseph Moore</u>				14. MOTHER'S MAIDEN NAME: <u>Mary ---</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY NO. <u>---</u>		17. INFORMANT & ADDRESS: <u>Mrs. Florence Moore, 219 S. Spring Ct.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocarditis chronic with failure</u>						<u>6 months</u>	
ANTECEDENT CAUSE (S) (B) <u>Myocardial hypertrophy</u>						<u>5 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Cerebral accident old.</u>						<u>unknown</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Mental confusion</u>						<u>unknown</u>	
19A. DATE OF OPERATION: <u>none</u>		19B. MAJOR FINDINGS OF OPERATION <u>no operation</u>				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY, street, office bldg., etc.) <u>no injury</u>		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR? <u>no injury</u>			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>no injury</u>		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>no injury</u>			
22. I hereby certify that I attended the deceased from <u>Dec 30, 1955</u> , to <u>Jan 8, 1956</u> that I last saw the deceased alive on <u>Jan 5, 1956</u> , and that death occurred at <u>12.30 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>J. Graham Manton</u>		M. D. <u>516 Cathedral Street</u>		DATE SIGNED <u>I-9-1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/11/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Peters Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/10/56</u>		REGISTRAR'S SIGNATURE <u>G.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Wm Cook Inc.</u>		ADDRESS <u>1217 St. Paul St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) DUNBAR LENGTH OF STAY (in this place)  
 TOWN DUNBAR  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS 2900 DUNBAR RD

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY BALTO  
 CITY (If outside corporate limits, write RURAL and give nearest town) SPARROW POINT X  
 OR TOWN SPARROW POINT  
 STREET ADDRESS (If rural give location) 1254 HADDAWAY RD

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
 (Type or Print) CHRISTINE OLA MORRIS

## 4. DATE OF DEATH:

(Month) (Day) (Year)  
JAN 23 1956

## 5. SEX:

FEMALE

## 6. COLOR OR RACE:

WHITE

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)

SINGLE

## 8. DATE OF BIRTH:

AUG 15, 1955

## 9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

yrs. Months Days Hours Min.  
5 8

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired:

NONE

## 10b. KIND OF BUSINESS OR INDUSTRY:

BALTIMORE MD

## 11. BIRTHPLACE (State or foreign country):

BALTIMORE MD

## 12. CITIZEN OF WHAT COUNTRY?

U.S.A.

## 13. FATHER'S NAME:

WALLACE MORRIS

## 14. MOTHER'S MAIDEN NAME:

LEOLA SHIFFLETT

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NO

## 16. SOCIAL SECURITY NO.:

—

## 17. INFORMANT &amp; ADDRESS:

WALLACE MORRIS 1254 HADDAWAY RD

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490X  
 Immediate cause

(a) Pneumonia, Cerebral  
 DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

Interval Between Onset And Death

24 hrs.

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

SUICIDE

## PLACE (Home, farm, factory, street, office bldg., etc.)

INJURY

## (CITY OR TOWN)

STANARDVILLE

## (COUNTY)

VA.

## (STATE)

VA.

## TIME (Month) (Day) (Year) (Hour) OF INJURY

22 Jan 1956 6 AM

INJURY OCCURRED While at Work ☐ Not While At Work ☐

m. 2900 Dunbar Rd

## HOW DID INJURY OCCUR?

2900 Dunbar Rd

22. I hereby certify that I attended the deceased from 22 Jan, 1956 to 23 Jan, 1956, that I last saw the deceased alive on 22 Jan, 1956, and that death occurred at 6 AM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

REMOVAL

## DATE THEREOF

JAN 24, 1956

## NAME OF CEMETERY OR CREMATORY

EVER GREEN

## LOCATION (City, town, or county)

STANARDVILLE

## (State)

VA.

## DATE REC'D BY LOCAL REGISTRAR

JAN 23-1956

## REGISTRAR'S SIGNATURE

William M Kelly

## 24. FUNERAL DIRECTOR

VULRICH FUNERAL HOME

## ADDRESS

2112 DUNBAR

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 25 1956

BUREAU V. S.



333

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00322

Item 18 Film G193 2-23-56 ams

## CERTIFICATE OF DEATH

Reg. Dist. No.

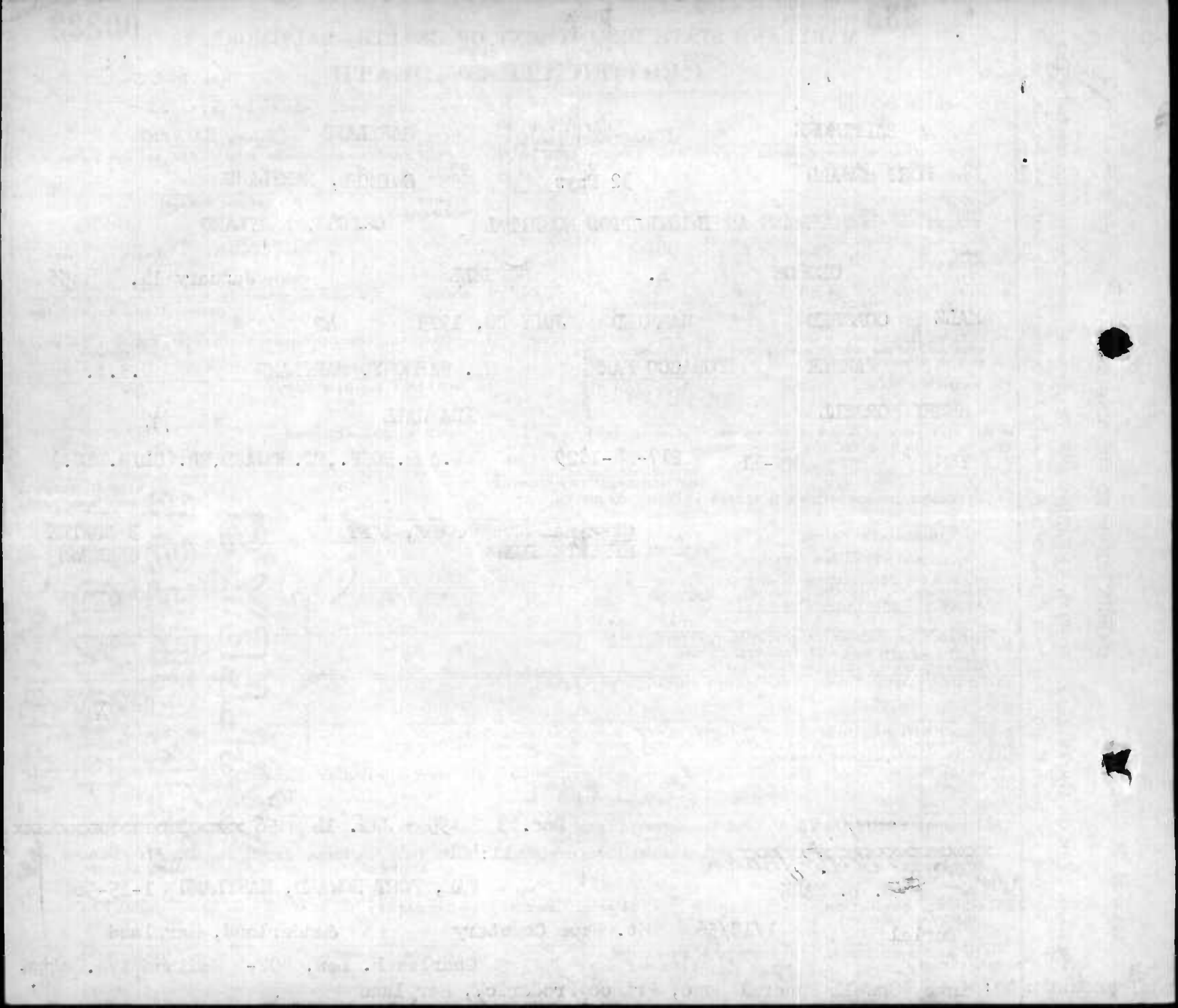
PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>CALVERT</b>	
CITY (If outside corporate limits, write RURAL OR TOWN <b>FORT HOWARD</b> )		LENGTH OF STAY (in this place) <b>32 Days</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>OWINGS, MARYLAND</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>OWINGS, MARYLAND</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<b>GEORGE B. MORSELL</b>				DEATH: <b>January 14, 1956</b>			
5. SEX: <b>MALE</b>	6. COLOR OR RACE: <b>COLORED</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <b>MARRIED</b>	8. DATE OF BIRTH: <b>JULY 20, 1913</b>	9. AGE last birthday <b>42</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>FARMER</b>			10B. KIND OF BUSINESS OR INDUSTRY: <b>TOBACCO FARM</b>	11. BIRTHPLACE (State or foreign country): <b>MT. HARMONY, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME: <b>HENRY MORSELL</b>				14. MOTHER'S MAIDEN NAME: <b>IDA HALL</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service) <b>YES WW-11</b>				16. SOCIAL SECURITY NO. <b>217-28-1829</b>		17. INFORMANT & ADDRESS: <b>VET. ADM. HOSP., FT. HOWARD, MD. (CLIN. REC.)</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>CEREBRAL HEMORRHAGE, LEFT</b>						<b>3 MONTHS</b>	
ANTECEDENT CAUSE (B) <b>GLIOMA OF THE PONS WITH EXTENSION INTO THE LEFT CEREBRAL HEMISPHERE</b>						<b>UNKNOWN</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST.						<b>UNKNOWN</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that <b>VA</b> attended the deceased from <b>Dec. 13, 1955</b> , to <b>JAN. 14, 1956</b> , and that death occurred at <b>11:40 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>D. D. MARK</b>		ADDRESS <b>M. D. VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>1-15-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/18/56</b>		NAME OF CEMETERY OR CREMATORY <b>Mt. Hope Cemetery</b>		LOCATION (City, town, or county) (State) <b>Sunderland, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR <b>1-16-56</b>		REGISTRAR'S SIGNATURE <b>[Signature]</b>		24. FUNERAL DIRECTOR <b>Charles B. Law, 802-4 Madison Ave. Balto. Md.</b>		ADDRESS	

Released to: Pinky Sewell Funeral Home, Prince Frederick, Maryland

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53



**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00323

334

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Ruxton</u>				TOWN <u>Baltimore</u>		<u>3Y01.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorensen Nursing Home</u> <u>7912 Ruxway</u>				STREET ADDRESS (If rural give location) <u>5813 Bellona Ave.</u>			
<b>3. NAME OF DECEASED</b> (First) <u>Pauline</u> (Middle) <u>Marie</u> (Last) <u>Moss</u> (Type or Print) <u>(ALSO Moss)</u>				<b>4. DATE OF DEATH</b> (Month) <u>January</u> (Day) <u>2</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>11/22/1873</u>		<b>9. AGE last birthday</b> <u>82</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u></u> Days <u></u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Missouri</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>
<b>13. FATHER'S NAME</b> <u>George Schleifer</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Eva Bingold</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>NO.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Chas. T. Moss 5813 Bellona Ave.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>331X IMMEDIATE CAUSE (A)</b> <u>Cerebral hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>arteriosclerosis</u>						<u>?</u>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Hypertension</u>						<u>?</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>✓</u>				<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>✓</u>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <u>✓</u>				<b>21e. INJURY OCCURRED</b> <u>✓</u> <input type="checkbox"/> White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>✓</u>	
<b>22. I hereby certify that I attended the deceased from</b> <u>12-31-54</u> , to <u>1-2-56</u> , that I last saw the deceased alive on <u>1-2-56</u> , and that death occurred at <u>1:24</u> M., from the causes and on the date stated above.							
<b>SIGNATURE</b> <u>James G. Selfill</u>				<b>DATE SIGNED</b> <u>1-3-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>NAME OF CEMETERY OR CREMATORY</b> <u>St. Mary's, Govans</u>		<b>LOCATION (City, town, or county)</b> <u>Baltimore Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>1956 1/4/56</u>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>H.W. Jenkins and Sons Co. York Rd.</u>			
<b>DATE</b> <u>JAN 5</u>				<b>ADDRESS</b> <u>4905</u>			



## MARYLAND STATE DEPARTMENT OF HEALTH

00324

2411 N. Charles Street, Baltimore

335

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> <u>Sorensen Nursing Home</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u></u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Riderwood, Md</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>Riderwood</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorensen Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>434 E. Biddle Street</u>	
3. NAME OF DECEASED (Type or Print) <u>Mary C, Mullin</u>		4. DATE OF DEATH (Month) <u>Jan</u> (Day) <u>6</u> (Year) <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>Nov. 18, 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u></u>	9. AGE last birthday <u>76</u> yrs. If under 1 year Months <u>1</u> Days <u>19</u> If under 24 hrs. Hours <u></u> Min. <u></u>
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u></u>	
13. FATHER'S NAME <u>Martin J. Mullin</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Heaphy</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u></u> (If yes, give war or dates of service) <u></u>		16. SOCIAL SECURITY NO. <u></u>	
17. INFORMANT AND ADDRESS <u>Richard H. Lerch 265 Stanmore Road</u>			

## 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
422.1 Immediate cause (a) <u>Acute passive congestion lungs</u>		<u>24 hours</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Myocarditis with failure</u>		<u>2 months</u>
(c) <u>Hypertrophy myocardium</u>		<u>5 years</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Arteriosclerosis generalized.</u>		<u>10 years</u>
19a. DATE OF OPERATION <u>none</u>	19b. MAJOR FINDINGS OF OPERATION <u>no operation</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT (Specify) <u>no injury</u>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>INJURY none</u>	(CITY OR TOWN) <u>none</u> (COUNTY) <u></u> (STATE) <u></u>
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>no injury</u> m. <u></u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>none</u>

22. I hereby certify that I attended the deceased from 12-13-, 1955, to 1-6th, 1956, that I last saw the deceased alive on Jan 5th, 1956, and that death occurred at 5:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

JAN 8 - 1956

REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 11 1956

BUREAU V. S.



1. PLACE OF DEATH COUNTY <b>BALTO</b>		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>MD</b> COUNTY <b>BALTO</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>Cockeysville</b>		LENGTH OF STAY (in this place) <b>3 yrs</b>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Cockeysville</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>5 Shawan Rd</b>				STREET ADDRESS <b>5 Shawan Rd</b>	
3. NAME OF DECEASED (Type or Print) <b>Elizabeth MARGARET</b>		(First) (Middle) <b>MURPHY</b>		(Last) <b>MURPHY</b>	
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>WIDOW</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		8. DATE OF BIRTH <b>JAN 23 1883</b>	
13. FATHER'S NAME <b>William Jacobs</b>				9. AGE last birthday <b>72</b> yrs.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
				14. MOTHER'S MAIDEN NAME <b>Katherine Wolfe</b>	
				17. INFORMANT AND ADDRESS <b>Mrs Joseph L Ackerman Same</b>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION	
443X Immediate cause (a).....				Cerebral Hemorrhage	
Antecedent cause(s) (b).....				Hypertensive Cardiovascular Disease	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c).....					
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?	
22. I hereby certify, that I attended the deceased from <u>12/2/1955</u> , to <u>1/4/1956</u> , that I last saw the deceased alive on <u>12/30/1955</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.					
SIGNATURE <u>M. Quinn</u>		(Degree or title) <u>M.D.</u>		ADDRESS <u>1927 York Rd, TITONIUM</u> DATE SIGNED <u>1/4/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify)		DATE		NAME OF CEMETERY OR CREMATORY	
<u>BURIAL</u>		<u>JAN 7 1956</u>		<u>New Cathedral</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		LOCATION (City, town, or county) (State)	
<u>1/6/56</u>		<u>C. Redach</u>		<u>Balto MD</u>	
		24. FUNERAL DIRECTOR		ADDRESS	
		<u>H. Winkler &amp; Sons</u>		<u>4905 York Rd</u>	

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CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Baltimore</u>
CITY (If outside corporate limits, write RURAL or and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
X TOWN <u>MT Wilson</u>	<u>2 yrs 8 months</u>	<u>3001-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MT Wilson State Hospital</u>		STREET ADDRESS (If rural give location) <u>308 N. Broadway Balto 31</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<u>EYRIA RANDELLS MURPHY</u>		DATE OF DEATH: <u>1-29-1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>5-5-03</u>
9. AGE last birthday <u>52</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Mln.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>STEAM PIPE FITTER</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>OWEN YACHT CO.</u>	
11. BIRTHPLACE (State or foreign country): <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY: <u>U.S.A.</u>	
13. FATHER'S NAME: <u>William David Murphy</u>		14. MOTHER'S MAIDEN NAME: <u>Flora Mae Eric</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO.: <u>033-09-0029</u>	
17. INFORMANT & ADDRESS: <u>Frances Murphy wife 308 N. Broadway Balto 31</u>		18. MEDICAL CERTIFICATION	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Pulmonary Tuberculosis</u>		<u>2 yrs 10 mos</u>	
ANTECEDENT CAUSE (B) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5:13</u> , 1953, to <u>1-29</u> , 1956, that I last saw the deceased alive on <u>1-29</u> , 1956, and that death occurred at <u>11 A.M.</u> from the causes and on the date stated above.			
SIGNATURE <u>William Newman</u>		DATE SIGNED <u>1-29-56</u>	
ADDRESS <u>W. Va.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/30/56</u>	
NAME OF CEMETERY OR CREMATORY <u>Arsons W. Va.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>Jan 30, 1956</u>		REGISTRAR'S SIGNATURE <u>Harold A. Newell</u>	
24. FUNERAL DIRECTOR <u>Frank H. Newell - Pikeville</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 7 1956

RECEIVED

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

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## CERTIFICATE OF DEATH

00327

Reg. Dist. No. 31

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Woodlawn</u>		<u>10 days</u>		TOWN <u>Woodlawn</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1932 Summit Ave</u>				STREET ADDRESS (If rural give location) <u>1932 Summit Ave</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) (Middle) (Last) <u>JOHN - EDWARD - MYERS</u>				(Month) (Day) (Year) <u>Jan 24 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>M</u>	<u>White</u>	<u>Widowed</u>	<u>March 28-1872</u>	<u>83</u> yrs.	Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>own farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>William A Myers</u>				14. MOTHER'S MAIDEN NAME <u>Mary E Nolte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>No</u>		17. INFORMANT & ADDRESS <u>Mrs Samuel Myers - Reisterstown Md</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
422.1 IMMEDIATE CAUSE (A) <u>Pulmonary Edema</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic C.V. Disease with</u>				<u>2-3 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Cardiac Decompensation</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 19 49</u> , to <u>Jan 24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan 21</u> , 19 <u>56</u> , and that death occurred at <u>3 A</u> .M. from the causes and on the date stated above.							
SIGNATURE <u>Martin E. Stoppel</u>				ADDRESS (Street, city, town, state) <u>M.D. 481 Main, Reisterstown, Md.</u>			
				DATE SIGNED <u>1/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan 27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Pleasant Grove</u>		LOCATION (City, town, or county) (State) <u>Balto Co Md</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. Wm. E. Martin</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edw E Tipton</u>		ADDRESS <u>Hampstead Md</u>	
DATE <u>Jan. 26, 1956</u>							







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## CERTIFICATE OF DEATH

Reg. Dist. No.

44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fort Howard</u>		<u>1 Day</u>		TOWN <u>Baltimore</u> <u>3V01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>50 Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>430 N. Clinton Street</u>			
3. NAME OF DECEASED: (First) (Middle) (Last) <u>JAMES F. NEARY</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>January 30 1956</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>8/7/93</u>	9. AGE last birthday <u>62</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Operator Plant Op.</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Chemical Plant</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>James P. Neary</u>				14. MOTHER'S MAIDEN NAME: <u>Margaret Muldowney</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes WW-I</u>			16. SOCIAL SECURITY NO. <u>212 14 1973</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>		

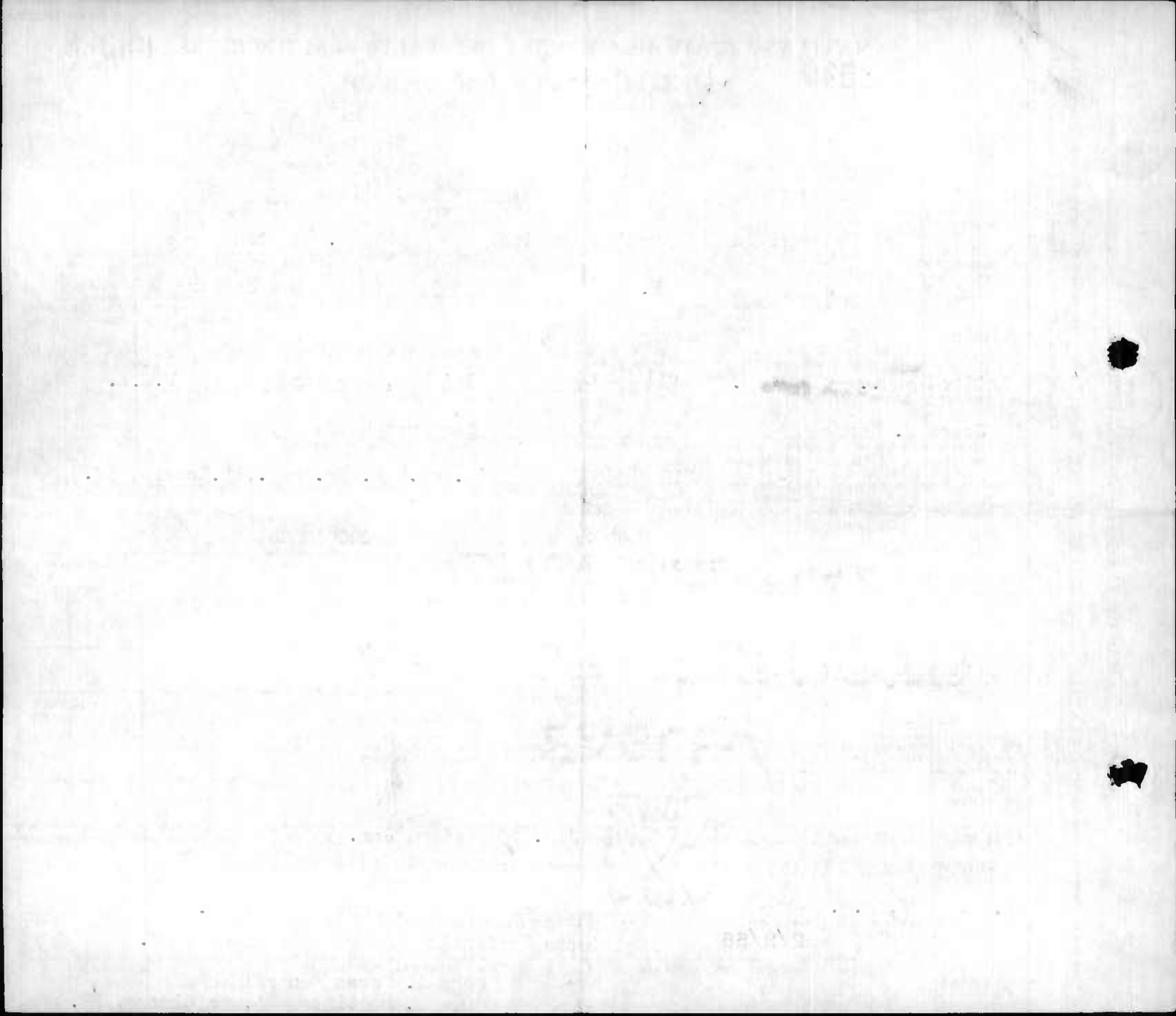
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE (A) <u>CARCINOMA OF THE HYPOPHARYNX WITH PERFORATION OF THE LARYNX</u>		UNKNOWN
ANTECEDENT CAUSE (B) <u>CARCINOMA OF PROSTATE</u>		UNKNOWN
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION <u>12/4/55</u>		19B. MAJOR FINDINGS OF OPERATION <u>(1) Bilateral orchidectomy (2) Tracheotomy</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 29, 1956</u> to <u>Jan. 30, 1956</u> , that I last saw the deceased <u>living</u> , and that death occurred at <u>5:00 P.M.</u> , from the causes and on the date stated above.				
SIGNATURE <u>D. D. MARK, M.D.</u>		ADDRESS <u>VAH, Fort Howard, Md.</u>		DATE SIGNED <u>1/31/56</u>
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>	DATE THEREOF <u>2/2/56</u>	NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u>	LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-7-56</u>	REGISTRAR'S SIGNATURE <u>[Signature]</u>	24. FUNERAL DIRECTOR <u>John A. Moran Funeral Home</u> <u>3000 E. Baltimore St. Baltimore, Md.</u>		

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

340

## CERTIFICATE OF DEATH

00329

Reg. Dist. No. 37

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Timonium</u>				TOWN <u>Timonium</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>133 Greenmeadow Drive</u>				STREET ADDRESS (If rural give location) <u>133 Greenmeadow Drive</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Arthur</u>		(Middle) <u>Nichols</u>		(Month) <u>Jan. 7,</u>		(Day) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Nov. 14, 1886</u>	9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Electrical</u>		11. BIRTHPLACE (State or foreign country) <u>Arglitte, Kentucky</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Jesse Nichols</u>				14. MOTHER'S MAIDEN NAME <u>Alydia Burton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>232-12-9092</u>		17. INFORMANT & ADDRESS <u>Mrs. Sarah Nichols-133 Greenmeadow Dr.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> Not while at work <input type="checkbox"/> While at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>JAN. 3<sup>rd</sup>, 1956</u> , to <u>JAN. 6<sup>th</sup>, 1956</u> , that I last saw the deceased alive on <u>JAN. 6<sup>th</sup>, 1956</u> , and that death occurred at <u>6:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>M. K. Quinn</u>				ADDRESS (Street, city, town, state) <u>York Rd, TIMONIUM Md.</u>		DATE SIGNED <u>1/9/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 10, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Moreland Memorial Park</u>		LOCATION (City, town, or county) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>JAN 10 1956</u>		REGISTRAR'S SIGNATURE <u>Mrs. Anne MacRae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lassahn Funeral Home - 7401 Belair Rd.</u>		ADDRESS	

9561 975N

RECEIVED

341

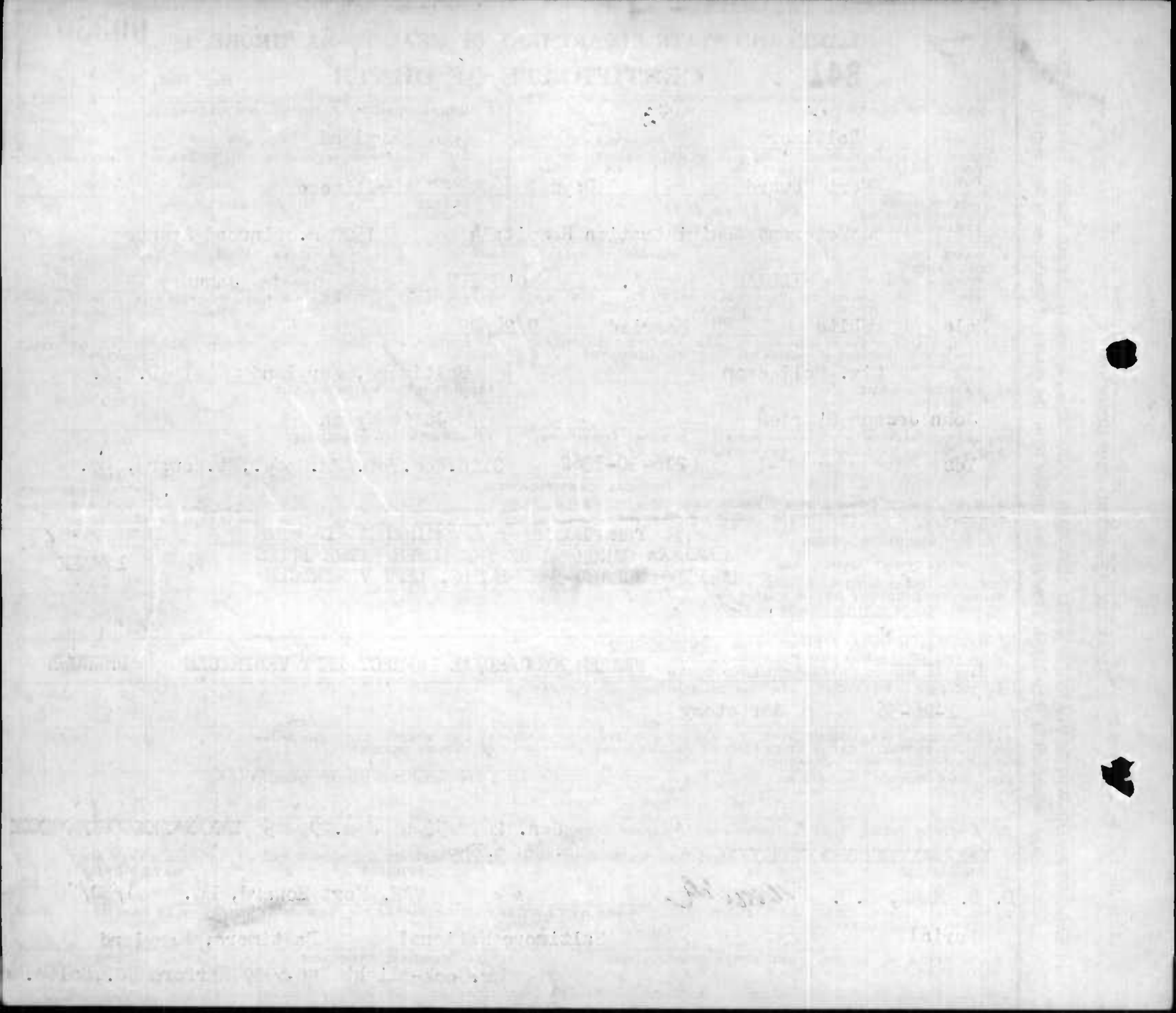
## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>3 Days</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<u>50 Veterans Administration Hospital</u>				<u>1500 N. Linwood Avenue</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>WILLIAM A. O'BRIEN</u>				<u>January 29 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>9/24/99</u>	<u>56 yrs.</u>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<u>Civ. Policeman</u>						<u>Baltimore, Maryland</u>	
13. FATHER'S NAME:				12. CITIZEN OF WHAT COUNTRY?			
<u>John Joseph O'Brien</u>				<u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<u>Yes</u> <u>WW-I</u>				<u>216-30-7362</u>		<u>Clin. Rec. Vet. Adm. Hosp., Ft. Howard, Md.</u>	
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
<u>420.1</u> IMMEDIATE CAUSE (A) <u>THROMBOSIS OF ABDOMINAL AORTA WITH</u>							
ANTECEDENT CAUSE (B) <u>XXVIB06 GANGRENE OF THE LOWER EXTREMITIES</u>							<u>1 WEEK</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>DOE TO MURAL - THROMBOSIS, LEFT VENTRICLE</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>HEALED MYOCARDIAL INFARCT LEFT VENTRICLE</u>							<u>UNKNOWN</u>
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
<u>1-26-56</u>		<u>Aortotomy</u>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 26, 1956, to Jan. 29, 1956, and that death occurred at 3:20 PM, from the causes and on the date stated above.							
SIGNATURE				DATE SIGNED			
<u>D. D. MARK, M.D.</u>				<u>VAH, Fort Howard, Md. 1/30/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>2-2-56</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-7-56</u>		<u>A. V. Hedrick</u>		<u>Wm. Cook-Blight Inc</u>		<u>6009 Harford Rd., Balto. Md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





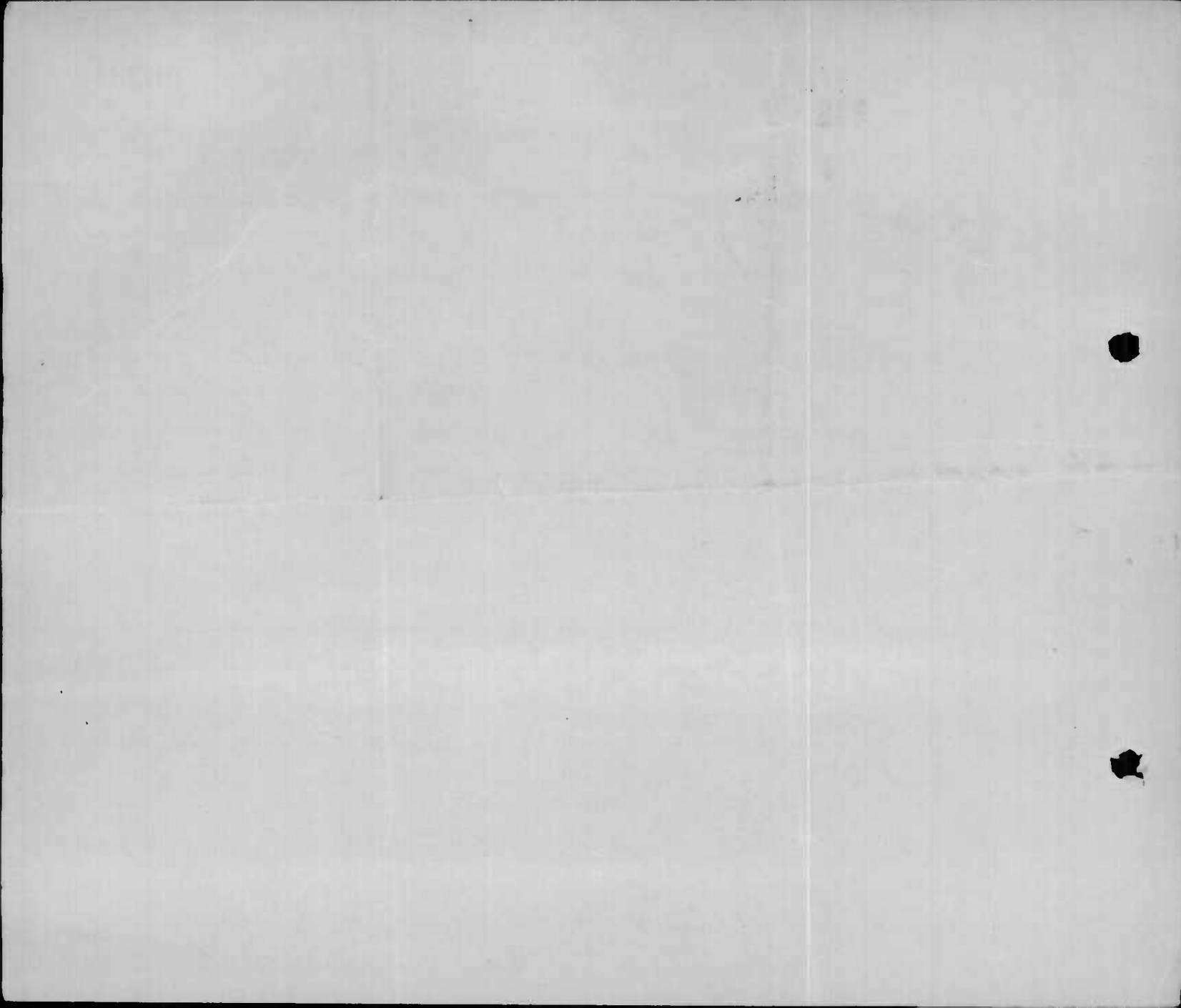
PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH  
**CERTIFICATE OF DEATH**  
 FOR MEDICAL EXAMINERS

00331

Reg. Dist. No. 36

1. PLACE OF DEATH- COUNTY <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <b>MD.</b> COUNTY <b>BALTIMORE</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>TIMONIUM</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>2340 YORK RD.</b>		STREET ADDRESS (If rural, give location) <b>2340 YORK RD.</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>SARAH</b> (Middle) <b>JANE</b> (Last) <b>O'NEILL</b>	4. DATE OF DEATH (Month) (Day) (Year) <b>JAN. 14 1956</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>SINGLE</b>	8. DATE OF BIRTH <b>?</b>
9. AGE last birthday <b>approx 80 yrs.</b>		10. IF under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN OWEN O'NEILL</b>		14. MOTHER'S MAIDEN NAME <b>MARY ELLEN O'NEILL</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY No. <b>—</b>	
17. INFORMANT AND ADDRESS <b>GEORGE D. O'NEILL, 6206 PINEHURST RD.</b>			
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>422.1</b> Immediate cause (a) <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b>			INTERVAL BETWEEN ONSET AND DEATH <b>20 YRS.</b>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> accident <input type="checkbox"/> suicide <input type="checkbox"/> homicide <input type="checkbox"/> undetermined <input type="checkbox"/>			
SIGNATURE <b>William A. Priestburg, M.D.</b>		ADDRESS <b>Timonium</b>	
23. FINAL CREMATION <input type="checkbox"/> BURIAL <input checked="" type="checkbox"/> (Specify)		DATE THEREOF <b>1-17-56</b>	
NAME OF CEMETERY OR CREMATORY <b>CATHERAL</b>		LOCATION (City, town, or county) (State) <b>BALTO.</b>	
DATE REC'D BY LOCAL REG. <b>1-16-56</b>		REGISTRAR'S SIGNATURE <b>Dr. Sedra</b>	
M. FUNERAL DIRECTOR <b>Greenfield &amp; Sons</b>		ADDRESS <b>322 N. 1st St.</b>	



343

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Towson LENGTH OF STAY (in this place)  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Sheppard & Enoch Pratt Hospital

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY  
 CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore  
 STREET ADDRESS (If rural give location) 3348 Keswick Road

## 3. NAME OF DECEASED:

(First) Carroll (Middle) Courtney (Last) Osborne

4. DATE OF DEATH: (Month) Jan. (Day) 6 (Year) 1956

## 5. SEX:

Male

## 6. COLOR OR RACE:

White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

## 8. DATE OF BIRTH:

1/27/87

## 9. AGE last birthday:

68 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Engineer

10b. KIND OF BUSINESS OR INDUSTRY: Hospital

11. BIRTHPLACE (State or foreign country): Baltimore County, Md.

12. CITIZEN OF WHAT COUNTRY? U S A

## 13. FATHER'S NAME:

?

## 14. MOTHER'S MAIDEN NAME:

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) unk

## 16. SOCIAL SECURITY No.:

212-32-1189

## 17. INFORMANT &amp; ADDRESS:

Employment Record - Sheppard-Pratt Hospital

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1  
 Immediate cause

(a) Cardio-vascular Disease - Coronary Occlusion  
 DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Cardiovascular Disease - Coronary Occlusion  
 DUE TO

(c) Arteriosclerosis

Interval Between Onset and Death

2 hrs.15 yrsunk

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

None

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify) None

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY None m.

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 6, 1956 to Jan 6, 1956, that I last saw the deceased alive on Jan 6, 1956, and that death occurred at 3:40 PM from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF

1/10/56

NAME OF CEMETERY OR CREMATORY

Parkwood

LOCATION (City, town, or county) (State)

Taylor Ave.

DATE REC'D BY LOCAL REGISTRAR Jan 7, 1956

REGISTRAR'S SIGNATURE

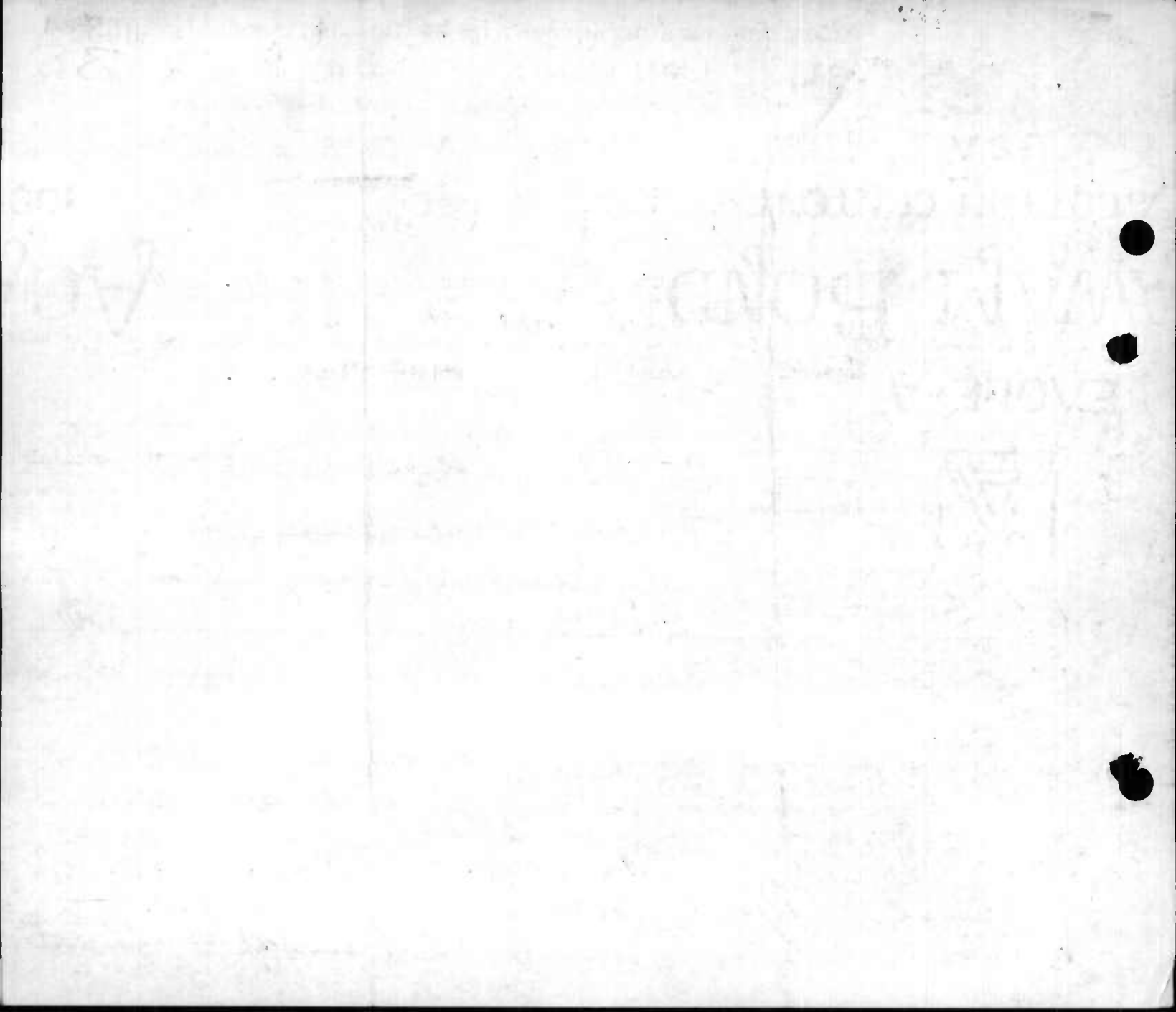
R.W.

24. FUNERAL DIRECTOR

Paul E. Cheneau 3615-17 Chestnut

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY BALTIMORE MARYLAND  
 CITY (If outside corporate limits, write RURAL LENGTH OF STAY  
 OR and give nearest town) (In this place)  
 TOWN CATONSVILLE  
 HOSPITAL OR  
 INSTITUTION OR CATON RIDGE HOME  
 STREET ADDRESS  
90

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MARYLAND COUNTY BALTO  
 CITY (If outside corporate limits, write RURAL and give nearest town)  
 OR  
 TOWN BALTIMORE 3Y01-4  
 STREET ADDRESS (If rural give location)  
1101 ANGESEA ST ✓

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

4. DATE OF DEATH:

(Month)

(Day)

(Year)

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): WIDOWED

## 8. DATE OF BIRTH:

9. AGE last birthday: 81 yrs.

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): IRON MOLDER10b. KIND OF BUSINESS OR INDUSTRY: FOUNDRY11. BIRTHPLACE (State or foreign country): PENNA

12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

GEORGE OTT

## 14. MOTHER'S MAIDEN NAME:

MARGARET WAGNER15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) NO

16. SOCIAL SECURITY No.:

17. INFORMANT &amp; ADDRESS:

PAUL OTT JR - 1101 ANGESEA ST

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Fracture Subtrochanteric femur left.

Interval Between Onset And Death

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

Dec 1955Fracture Subtrochanteric femur left

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. SUICIDE

(Specify)

PLACE (Home, farm, factory, street, office, bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY Dec 27 1955 11:30 AMINJURY OCCURRED While at Work ☐ Not While At Work ☒

HOW DID INJURY OCCUR?

Fell to floor at home22. I hereby certify that I attended the deceased from 1954 to 20 Jan, 1956, that I last saw the deceasedalive on 16 Jan, 1956, and that death occurred at 11:30 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

Wm. Scott A.D.1707 Edmondson Ave. Catonsville Md1/21/56

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE RECD BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

Jan 24, 1956J. B. PerryULLRICH FUNERAL HOME - 2112 DUNDALKAve

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 26 1956

RECEIVED



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00334

345

## CERTIFICATE OF DEATH

Reg. Dist. No. 45

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Balto.</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <i>Essey</i>				TOWN <i>Essey</i>		300 21	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>368 Edgewater Apt.</i>				STREET ADDRESS <i>368 Edgewater Apt.</i>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <i>Phoebe</i> (Middle) <i>Parks</i> (Last)				(Month) <i>1</i> (Day) <i>22</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>F</i>	<b>6. COLOR OR RACE</b> <i>W</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>married</i>	<b>8. DATE OF BIRTH</b> <i>May 18, 1895</i>	<b>9. AGE last birthday</b> <i>60</i> yrs.	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
				Months		Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>House wife</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>None</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>North Carolina</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <i>Mrs. M. Adams</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Martin E. Church</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>No</i>		<b>16. SOCIAL SECURITY NO.</b> <i>unknown</i>		<b>17. INFORMANT &amp; ADDRESS</b> <i>Robert Parks (same?)</i>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>155X IMMEDIATE CAUSE</b> (A) <i>Metastatic carcinoma of</i>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>4 mo.</i>			
<b>ANTECEDENT CAUSE(S) DUE TO</b> (B) <i>gall bladder</i>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (C) <i>gall bladder</i>							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <i>Oct 1955</i>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <i>Carcinoma gall bladder, inoperable</i>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town)		(County) (State)	
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>Sept 1955</i> , to <i>Jan 22, 1956</i> , that I last saw the deceased alive on <i>Jan 22, 1956</i> , and that death occurred at <i>8:15 P.M.</i> from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Louis Semeroff</i>				<b>ADDRESS</b> (Street, city, town, state) <i>M.D. 1437 Furbey Ave. Balto 20 Md</i>		<b>DATE SIGNED</b> <i>1/22/56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>Removal</i>		<b>DATE THEREOF</b> <i>1-23-56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>Fairview Cemetery</i>		<b>LOCATION</b> (City, town, or county) (State) <i>Smith Co. Va.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Edith Hurley</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>W. B. G. Smith</i>		<b>ADDRESS</b> <i>1417 Eastern Ave</i>	
<b>DATE</b> <i>1-24-56</i>							

CERTIFICATE OF DEATH

345

Form No. 10

1. Name of deceased

2. Sex

3. Race

4. Date of birth

5. Place of birth

6. Usual residence

7. Date of death

8. Time of death

9. Cause of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial

19. Signature of interment

20. Signature of cremation

21. Signature of disposition

22. Signature of record

23. Signature of filing

24. Signature of distribution

25. Signature of return

26. Signature of receipt

27. Signature of acknowledgment

28. Signature of approval

29. Signature of certification

30. Signature of attestation

31. Signature of authentication

32. Signature of attestation

33. Signature of attestation

34. Signature of attestation

35. Signature of attestation

36. Signature of attestation

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53. Signature of attestation

54. Signature of attestation

55. Signature of attestation

56. Signature of attestation

57. Signature of attestation

BUREAU V. S.

JAN 26 1956

RECEIVED

RECEIVED

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00335

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

Film G-191 1/27/56

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTO</u>		STATE <u>MD</u> COUNTY <u>BALTO</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>		TOWN <u>SPARROWS POINT</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>SPARROWS POINT</u>		LENGTH OF STAY (in this place) <u>4</u> days		STREET ADDRESS (If rural give location) <u>915 E ST.</u>		TOWN <u>SPARROWS POINT</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>68 Admiral Blvd.</u>				STREET ADDRESS <u>915 E ST.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ISABELLA</u> (First) <u>PATERSON</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>1</u> (Day) <u>22</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>FEM.</u>	<b>6. COLOR OR RACE</b> <u>WHITE.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED</b> (Specify) <u>SINGLE</u>	<b>8. DATE OF BIRTH</b> <u>22 SEPT. 1883</u>	<b>9. AGE last birthday</b> <u>72</u> yrs.	<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEKEEPER</u>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>HOME</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>ENGLAND</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>
<b>13. FATHER'S NAME</b> <u>JOHN PATERSON</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>ALICE DRESSER</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>MRS. A. SIDNEY HACKMAN - Same</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>IMMEDIATE CAUSE (A)</b> <u>Pulmonary Edema</u>				<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>2 hours</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <u>Ventricular Fibrillation (probable)</u>				<u>2 hours</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b> <u>Hypertensive Arteriosclerotic Cardiovascular Disease</u>				<u>at least 10 yrs.</u>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Dec. 1</u>, 19<u>55</u>, to <u>Jan. 22</u>, 19<u>56</u>, that I last saw the deceased alive on <u>Dec. 20</u>, 19<u>55</u>, and that death occurred at <u>6 A.</u> M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>David Quasius</u>				<b>ADDRESS</b> (Street, city, town, state) <u>914 D Street Sparrows Point, Md.</u>		<b>DATE SIGNED</b> <u>Jan 19, 1956</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>1-25-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>LOU DON PARK</u>		<b>LOCATION (City, town, or county)</b> <u>BALTO., MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Dawson S. Farley</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Walter Burke Pridley, Randolph, Md.</u>		<b>ADDRESS</b>	
<b>DATE</b> <u>Jan 24-56</u>							



1

INSTRUCTIONS

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

348

## CERTIFICATE OF DEATH

00336

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>Catonsville</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>52</u> TOWN <u>Catonsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u> <u>201 S.Symington Ave</u>				STREET ADDRESS (If rural give location) <u>201 S.Symington Ave.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>EMMA</u> (Middle) <u>MAY</u> (Last) <u>PAYNE</u>				(Month) <u>Jan.</u> (Day) <u>24</u> (Year) <u>19 56</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>11-22-1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>At Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Henry Meeth</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Tribbie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Herbert Payne, Ellicott City, Md</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
IMMEDIATE CAUSE (A) <u>421.1 CONGESTIVE CARDIAC FAILURE</u>						<u>CHRONIC</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>AORTIC STENOSIS</u>						<u>CONGENITAL</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>NEPHROSCLEROSIS</u>						<u>YEARS</u>	
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>MAY</u> , 19 <u>53</u> , to <u>JAN.</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>JAN 24</u> , 19 <u>56</u> , and that death occurred at <u>4:45 P.M.</u> from the causes and on the date stated above. <b>SIGNATURE</b> <u>Donald E. Tophers</u> <b>M.D.</b> <u>Ellicott City</u> <b>DATE SIGNED</b> <u>1-25-56</u> <b>ADDRESS</b> (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>Salem Lutheran</u>		LOCATION (City, town, or county) (State) <u>Catonsville, Md</u>	
24. REC'D BY REGISTRAR <u>1-27-56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mac Nabb &amp; Son. Catonsville, Md.</u>			



# CERTIFICATE OF DEATH

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Page One of Two

DEPARTMENT OF HEALTH, BALTIMORE, MARYLAND

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

Cause of Death

Age at Death

Place of Birth

Residence at Death

Sex

Color

Marital Status

Occupation

Education

Religion

Previous Illnesses

Medical History

Family History

Signature of Physician

Signature of Registrar

Signature of Coroner

Signature of Medical Examiner

Signature of Health Officer

Signature of Burial Officer

Signature of Undertaker

Signature of Funeral Home

Signature of Cemetery

Signature of Graveyard

Signature of Interment

Signature of Burial

Signature of Final Disposition

Signature of Record

Signature of File

Signature of Index

Signature of Distribution

Signature of Release

Signature of Return

Signature of Acknowledgment

Signature of Receipt

Signature of Discharge

Signature of Final Report

Signature of Closing

Signature of End

BUREAU V. S.

JAN 30 1936

RECEIVED

2007/12/21



247

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>MT. WILSON</u> <u>Baltimore</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)				CITY (If outside corporate limits, write RURAL and give nearest town)			
<u>X</u> TOWN <u>17 months</u>				OR TOWN <u>BALTIMORE</u> <u>3401-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>MT. WILSON STATE Hospital</u>				STREET ADDRESS (If rural give location) <u>1837 WEST PRATT ST.</u> ✓			
3. NAME OF DECEASED: (Type or Print)				4. DATE (Month) (Day) (Year)			
<u>(First) MILTON (Middle) BARTH (Last) PELTZ</u>				OF DEATH: <u>JAN. 22</u> <u>1956</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>WIDOWED</u>		8. DATE OF BIRTH: <u>2.28.1904</u>	
				9. AGE last birthday: <u>51</u> yrs.		10. IF UNDER 1 YEAR Months Days	
						11. IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>AUTO-MECHANIC</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>SELF EMPLOYED</u>			
11. BIRTHPLACE (State or foreign country): <u>NORFOLK, VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME: <u>MILTON PELTZ</u>				14. MOTHER'S MAIDEN NAME: <u>MOLLY SCHLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>NO</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>212-34-5737</u>			
17. INFORMANT & ADDRESS: <u>Hospital Records</u>				<u>MT Wilson State Hospital, Mt Wilson, Md</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>002X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>FAR ADVANCED PULMONARY TUBERCULOSIS</u>							
DUE TO							
(B) <u>MILIARY TUBERCULOSIS</u>							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.			
				21C. WHERE DID (City or town) (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			
				21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5</u> <u>19</u> , 19 <u>54</u> , to <u>1.22</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1.22</u> , 19 <u>56</u> , and that death occurred at <u>5:55</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>William Newman</u>				ADDRESS <u>1.22.56</u>			
DATE REC'D BY LOCAL REGISTRAR <u>12/3/56</u>				REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				DATE THEREOF <u>1-24-56</u>			
NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>				LOCATION (City, town, or county) (State) <u>Balto., Md.</u>			
24. FUNERAL DIRECTOR <u>Howard H. Hubbard</u>				ADDRESS <u>1127 Wilkes Ave</u>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1111  
MAY 1 1961  
RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00338

349

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Parkville</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>		TOWN <b>Baltimore</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Oak Haven Nursing Home 9008 Harford Road #14</b>				STREET ADDRESS (If rural give location) <b>3118 Mary Avenue #14</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Mrs. Frances B. Peshek</b>				<b>4. DATE OF DEATH</b> (Month) <b>January</b> (Day) <b>20</b> (Year) <b>19 56</b>			
<b>5. SEX</b> <b>female</b>	<b>6. COLOR OR RACE</b> <b>white</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>single</b>	<b>8. DATE OF BIRTH</b> <b>May 10, 1872</b>	<b>9. AGE last birthday</b> <b>83</b> yrs.	<b>IF UNDER 1 YEAR</b> (Months) <b>Days</b>		<b>IF UNDER 24 HRS.</b> (Hours) <b>Min.</b>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>?</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>?</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mrs. Beatrice Howard, 3118 Mary Avenue</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.1 IMMEDIATE CAUSE (A)</b> <b>CORONARY Arteriosclerosis</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> <b>Generalized Arteriosclerosis</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED White at work Not white at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Sept 18, 1953, to Jan 20, 1956, that I last saw the deceased alive on Jan 18, 1956, and that death occurred at 2:40 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>Charles V. Sevier</b> M.D.				<b>ADDRESS</b> (Street, city, town, state) <b>5701 Belair Rd.</b>		<b>DATE SIGNED</b> <b>1/21/56</b> (State)	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>1/23/56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Baltimore, Md.</b>	
<b>24. REC'D BY REGISTRAR</b> <b>N 23 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Dr. A. M. Bacon</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>			

100-338

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

# CERTIFICATE OF DEATH

Form 10-1-1950

ATTEST: REGISTRAR OF DEATHS

DATE OF DEATH

NAME OF DECEASED

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

CAUSE OF DEATH

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CAUSE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

RECEIVED

RECEIVED JAN 24 1956

BUREAU V. S.

JAN 24 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00339

208

## CERTIFICATE OF DEATH

Reg. Dist. No. 47

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md.</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Arbutus</u>		<u>6 weeks</u>		TOWN <u>Arbutus</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1206 Greystone Rd.</u>				STREET ADDRESS (If rural give location) <u>1206 Greystone Rd.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Jean</u> (Middle) <u>L.</u> (Last) <u>Pfeifer</u>				(Month) <u>Jan</u> (Day) <u>6</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>6/10/1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. #1 St.</u>		11. BIRTHPLACE (State or foreign country) <u>Lincoln Maine</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Edward M. Kelly</u>				14. MOTHER'S MAIDEN NAME <u>Sophia E. Davis</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>Mr. Le Roy V. Pfeifer 1206 Rd. Greystone</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
193X IMMEDIATE CAUSE (A) <u>Carcinoma Brain</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>2/1</u> , 19 <u>54</u> , to <u>1/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/5</u> , 19 <u>56</u> , and that death occurred at <u>6:30</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>John B. Healy</u>				M.D. <u>Dale Thompson, Md.</u>		DATE SIGNED <u>1/6/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/9/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cem.</u>		LOCATION (City, town, or county) <u>Dogwood Rd.</u> (State) <u>Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Dr. Geo. S. M. Kieffer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan &amp; Son</u>		ADDRESS <u>1206 Rd. Greystone</u>	
DATE <u>Jan. 6, 1956</u>							



108303

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

# CERTIFICATE OF DEATH

508

1. NAME OF DECEASED		2. PLACE OF BIRTH	
3. SEX		4. AGE	
5. DATE OF DEATH		6. TIME OF DEATH	
7. CAUSE OF DEATH		8. PLACE OF DEATH	
9. MANNER OF DEATH		10. SIGNATURE OF DECEASED	
11. SIGNATURE OF WITNESSES		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF CLERK		14. SIGNATURE OF JURY	
15. SIGNATURE OF JUDGE		16. SIGNATURE OF SHERIFF	
17. SIGNATURE OF CORONER		18. SIGNATURE OF TOWNSHIP CLERK	
19. SIGNATURE OF COUNTY CLERK		20. SIGNATURE OF STATE CLERK	

BUREAU V. S.

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00340

349

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Fullerton</u>		<u>Life</u>		TOWN <u>Fullerton</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>4327 Ridge Road</u>				STREET ADDRESS (If rural give location) <u>4327 Ridge Road</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Albert Pfeiffer Sr.</u>				<u>January 13, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>October 19, 1886</u>	<u>69</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Fireman</u>		<u>Glenn Martin Co.</u>		<u>Baltimore County, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME <u>David Pfeiffer</u>				14. MOTHER'S MAIDEN NAME <u>Christina Kvoll</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>220-24-7491</u>		<u>Mrs. Albert Pfeiffer-4327 Ridge Road</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						<u>2 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerotic Cardiovascular Disease</u>						<u>many years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June, 1955</u> , to <u>Jan 13, 1956</u> , that I last saw the deceased alive on <u>Jan 13, 1956</u> , and that death occurred at <u>10p.m.</u> from the causes and on the date stated above.							
SIGNATURE <u>Max R. English</u>		M.D. <u>5713</u>		ADDRESS (Street, city, town, state) <u>Belair Rd Balt 6 md</u>		DATE SIGNED <u>1-14-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 16, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Parkwood</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Mrs. H. L. Reif...</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Larsen Funeral Home</u>		ADDRESS <u>7401 Belair Road</u>	
DATE <u>Jan 20, 1956</u>							

# CERTIFICATE OF DEATH

Form 100-10-1

1. NAME OF DECEASED (Print or Type)

2. SEX (Male or Female)

3. RACE (Print or Type)

4. DATE OF BIRTH (Print or Type)

5. PLACE OF BIRTH (Print or Type)

6. OCCUPATION (Print or Type)

7. CAUSE OF DEATH (Print or Type)

8. MANNER OF DEATH (Print or Type)

9. TIME OF DEATH (Print or Type)

10. PLACE OF DEATH (Print or Type)

11. SIGNATURE OF PHYSICIAN (Print or Type)

12. SIGNATURE OF MINISTER (Print or Type)

13. SIGNATURE OF CORONER (Print or Type)

14. SIGNATURE OF DECEASED (Print or Type)

15. SEX (Male or Female)

16. RACE (Print or Type)

17. DATE OF BIRTH (Print or Type)

18. PLACE OF BIRTH (Print or Type)

19. OCCUPATION (Print or Type)

20. CAUSE OF DEATH (Print or Type)

21. MANNER OF DEATH (Print or Type)

22. TIME OF DEATH (Print or Type)

23. PLACE OF DEATH (Print or Type)

BUREAU V. 2

JAN 20 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00341

350

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH COUNTY <u>BALTIMORE</u> STATE <u>MARYLAND</u> CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>CATONSVILLE</u> LENGTH OF STAY (in this place) <u>7 Mos.</u> TOWN <u>CATONSVILLE</u>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>MARYLAND</u> COUNTY <u>3001-4</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u> OR TOWN <u>CITY</u> STREET ADDRESS (If rural give location) <u>5126 CRAIG AVE.</u>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>GRACE E. PILSON</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>1-4-56</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>SINGLE</u>	8. DATE OF BIRTH <u>JULY 10-1883</u>	9. AGE last birthday <u>72</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CLERK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>ABRAHAM PILSON</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH BEANS.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-07-8624</u>		17. INFORMANT & ADDRESS <u>ROBERT M. PILSON 5126 CRAIG AVE.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 420.1 IMMEDIATE CAUSE (A) <u>Acute Coronary Occlusion</u> ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio Sclerosis with Hypertension</u> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>and Cardiac Hypertrophy</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour.</u> <u>14 years.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED				21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7/21/43</u> to <u>1/4/56</u> , that I last saw the deceased alive on <u>1/4/56</u> , and that death occurred at <u>10:25 p.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>W. B. Levin MD</u>		ADDRESS (Street, city, town, state) <u>M.D. 2156 University Parkway - Balto 15, Md 1157</u>		DATE SIGNED <u>1/4/56</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	DATE THEREOF <u>1-7-56</u>	NAME OF CEMETERY OR CREMATORY <u>LOUDON PT. CEM.</u>		LOCATION (City, town, or county) (State) <u>BALTO MD.</u>			
24. REC'D BY REGISTRAR <u>Jan. 6, 1956</u>	REGISTRAR'S SIGNATURE <u>V. E. Harry</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>V. H. Jenkins</u>		ADDRESS <u>4905 York Rd.</u>		

JAN 9 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

00342

Reg. Dist. No. 40

1. PLACE OF DEATH <u>Baltimore County</u>				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Glen Arm</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Glen Arm</u>		-----		TOWN <u>Glen Arm</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>Henry E. Plack</u>				4. DATE OF DEATH <u>1/1/56</u>			
(First)		(Middle)		(Last)		(Year)	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>3/5/71</u>	9. AGE last birthday <u>84</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
				Months		Days	Hours
						Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>		11. BIRTHPLACE (State or foreign country) <u>Badenkopff, Germany</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>unknown</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS <u>Rev. Paul Plack, Montoursville, Pa.</u>			
(If Yes, give war or dates of service)							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<u>422.1</u>				<u>Cerebral Thrombosis</u>		<u>23 mos.</u>	
IMMEDIATE CAUSE (A)				<u>Arteriosclerotic Cardiovascular Disease</u>		<u>4 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg, etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>June 11, 1957</u> , to <u>Jan 1, 1956</u> , that I last saw the deceased alive on <u>Dec 31, 1955</u> , and that death occurred at <u>1:30 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Jefford F. Hudson</u> M.D.				ADDRESS (Street, city, town, state) <u>Fork, Md.</u> DATE SIGNED <u>1/2/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Fork Methodist</u>		LOCATION (City, town, or county) (State) <u>Fork, Maryland</u>	
24. REC'D BY REGISTRAR <u>JAN 3 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter Hammett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook-Blight, Inc.</u>		ADDRESS <u>6009 Hayford Road</u>	







352  
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00343  
 Reg. Dist.

No. 33

1. PLACE OF DEATH: COUNTY <u>Baltimore</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Reisterstown Rt. 2</u> TOWN <u>Reisterstown Rt. 2</u> LENGTH OF STAY (In this place) <u>22 years</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Nicodemus Road</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Reisterstown Rt. 2</u> TOWN <u>Reisterstown Rt. 2</u> STREET ADDRESS (If rural, give location) <u>Nicodemus Road</u>			
3. NAME OF DECEASED: (First) <u>John</u> (Middle) <u>Nicholas</u> (Last) <u>Pohlman</u> (Type or Print)			4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>21</u> (Year) <u>1956</u>				
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH: <u>Sept. 28, 1893</u>	9. AGE last birthday: <u>62</u> yrs.	IF UNDER 1 YEAR Months <u>    </u> Days <u>    </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Machinist</u>			10b. KIND OF BUSINESS OR INDUSTRY: <u>Stokers</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		
13. FATHER'S NAME: <u>John N. Pohlman</u>			14. MOTHER'S MAIDEN NAME: <u>Ida Armola Yingling</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>215-09-3010</u>		17. INFORMANT & ADDRESS: <u>Mrs. John Pohlman, Reisterstown, Md.</u>			

18. MEDICAL CERTIFICATION I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Coronary Occlusion</u> DUE TO Antecedent cause(s) (b) <u>Coronary Thrombosis</u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Angina Pectoris</u> <u>Arteriosclerotic C-V Disease</u>					INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>4 yrs.</u> <u>5 yrs.</u> <u>6-7 yrs.</u>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.					
19a. DATE OF OPERATION: <u>none</u>		19b. MAJOR FINDING OF OPERATION: <u>none</u>		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>none</u>	21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) <u>none</u>	21c. (City or town) (County) (State) <u>none</u>		21f. HOW DID INJURY OCCUR? <u>none</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21g. HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>J. A. Caples</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>1-23-56</u> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM.					
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan. 25, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Park Cemetery</u>	
DATE REC'D BY LOCAL REG. <u>1-23-56</u>		REGISTRAR'S SIGNATURE <u>Mary B. Eline</u>		24. FUNERAL DIRECTOR <u>Wm. Berryman &amp; Sons, Reisterstown, Md.</u>	

RECEIVED

JAN 25 1956

BUREAU V. S.

353

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 30

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Catonsville</u> TOWN		MARYLAND LENGTH OF STAY (In this place) <u>2yr. 3mt. 12days</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>SPRING GROVE STATE HOSP.</u>		STREET ADDRESS (If rural, give location) <u>1601 Wilson Pt. Rd. - Balto. 20</u>			
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)	4. DATE OF DEATH	(Month) (Day) (Year)
	<u>Alice</u>	<u>B.</u>	<u>Potter</u>	<u>1-10-56</u>	<u>19</u>
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)	8. DATE OF BIRTH	9. AGE last birthday	If under 1 year If under 24 hrs.
<u>female</u>	<u>white</u>	<u>widowed</u>	<u>Oct. 1, 1877</u>	<u>78</u> yrs.	Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
<u>housewife</u>			<u>Maryland - Baltimore</u>		<u>U.S.A.</u>
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
<u>John Gearish</u>			<u>Elizabeth ? Bennet</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	17. INFORMANT AND ADDRESS		
<u>unknown</u>		<u>unknown</u>	<u>Records of Spring Grove State Hospital</u>		

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause

(a)

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING

PLACE (Home, farm, factory, street, OF office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at work ☐ Not while at work ☒

HOW DID INJURY OCCUR?

22. I certify that I took charge of the remains described above, held an Autopsy ☐ Inspection ☒ Inquiry ☒ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☐ accident ☐ suicide ☒ homicide ☐ undetermined ☐

SIGNATURE

(Doctor or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

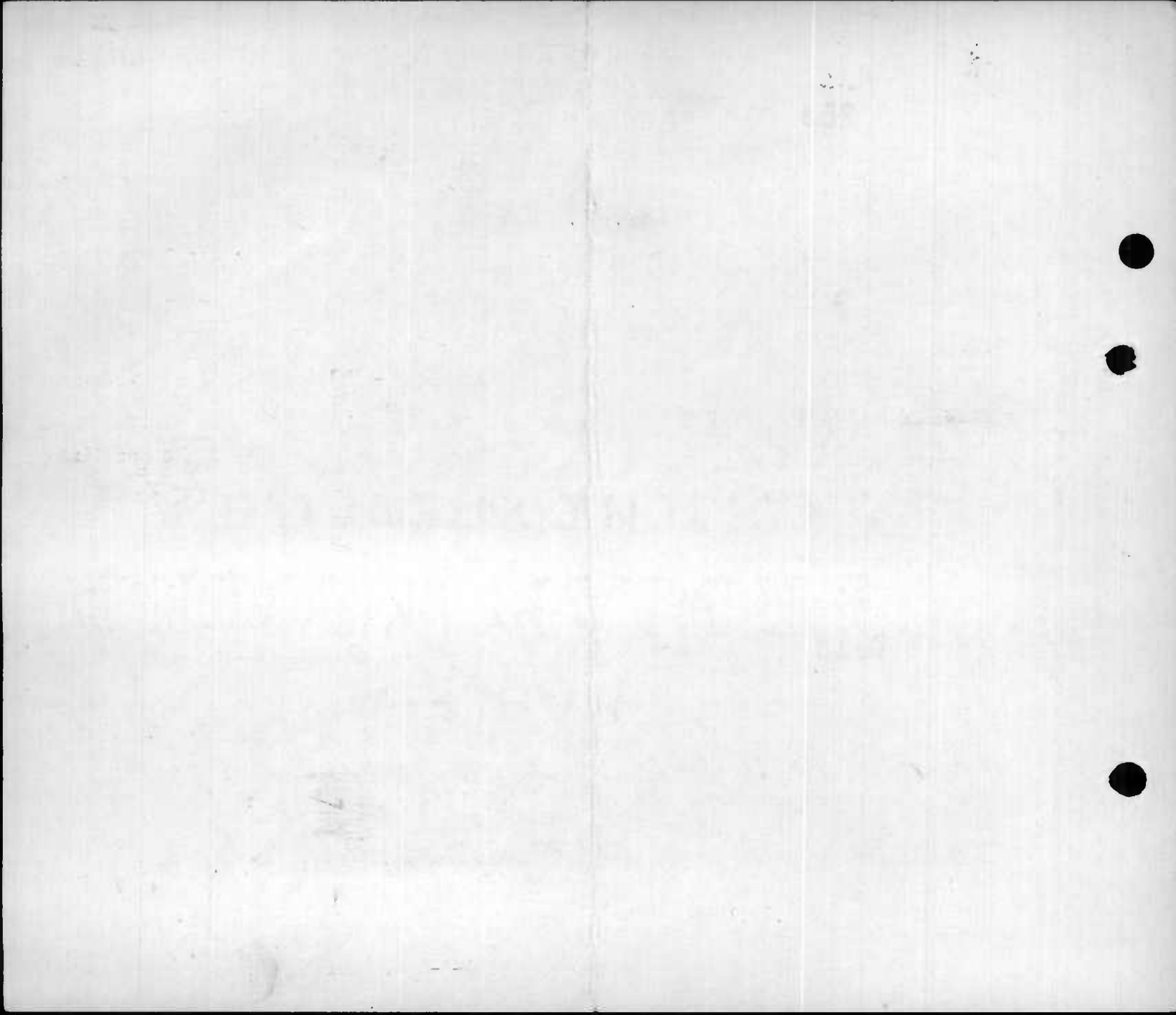
ADDRESS

Schimunek Funeral Home, Inc.

2601-3-5 E. Madison St.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



354

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY Baltimore		MARYLAND	STATE Md.		COUNTY Balto.
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town)		
TOWN Edgemere		30yrs	TOWN Edgemere Md.		
HOSPITAL OR INSTITUTION OR STREET ADDRESS			STREET ADDRESS (If rural give location)		
			3119 Grace Ave. Road 19		
3. NAME OF DECEASED:			4. DATE OF DEATH:		
(First) (Middle) (Last)			(Month) (Dry) (Year)		
Benjamin F. Reese			Jan 2 19 56		
5. SEX:		6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:
Male		White	Married		June 10, 1880
9. AGE last birthday:		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):		11. BIRTHPLACE (State or foreign country):	
75 yrs.		Machinist		Pa,	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
		Benjamin Reese		Sarah Wildman	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.:		17. INFORMANT & ADDRESS:	
		213-07-2364		Mrs. Minnie Reese, 3119 Garce Rd. 19	

18. MEDICAL CERTIFICATION			Interval Between Onset And Death		
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH					
Immediate cause (a) <i>Acute Bronchopneumonia</i>					
Antecedent causes (b) <i>Severe anemia and atelectasis</i>					
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>Lymphomatous disease. Probably Hodgkin's Disease</i>					
11. OTHER SIGNIFICANT CONDITIONS					
Conditions contributing to the death but not related to the disease or condition causing death.					
19a. DATE OF OPERATION:			19b. MAJOR FINDINGS OF OPERATION		
20. AUTOPSY ?			Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>		
21. ACCIDENT SUICIDE HOMICIDE (Specify)			PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)		
TIME (Month) (Day) (Year) (Hour) OF INJURY			INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
			HOW DID INJURY OCCUR ?		
22. I hereby certify that I attended the deceased from <i>December 28</i> , 19 <i>53</i> , to <i>Jan 2</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>Jan 1</i> , 19 <i>56</i> , and that death occurred at <i>7:24</i> , from the causes and on the date stated above.					
SIGNATURE (Degree or title) ADDRESS DATE SIGNED					
<i>David Owens, M.D.</i> <i>914 D Street Sparks Road 19 Md.</i> <i>1/3/56</i>					
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		Jan. 5/56		Moreland Mem. Park	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR	
<i>Jan 3 - 1956</i>		<i>Darwin L. Harbor</i>		<i>Philips Hewig</i>	
				ADDRESS	
				2024 Orleans St. 31	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 5 1956

BUREAU V. S.

INSTRUCTIONS



00346

209

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTIMORE</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>BALTIMORE</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LANSDOWNE</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>LANSDOWNE</u>		51	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1726 HALL AVE.</u>				STREET ADDRESS (If rural give location) <u>1726 HALL AVE</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>Josephine C. REILEY</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>JANUARY 23, 1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>DEC. 15, 1891</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>IRELAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>REGAN</u>				14. MOTHER'S MAIDEN NAME <u>Un Known</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>Joseph REILEY 1726 HALL AVE</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
260X IMMEDIATE CAUSE (A) <u>Diabetes mellitus</u>						<u>6 mos</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio-sclerotic heart disease</u>						<u>6 mos</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>C failure</u>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (M.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from May 1, 1955, to July 12, 1956, that I last saw the deceased alive on July 22, 1956, and that death occurred at 2 P.M. from the causes and on the date stated above.</b>							
SIGNATURE <u>Benjamin Miller MD</u>				ADDRESS (Street, city, town, state) <u>1301 Wilkens ave</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-25-56</u>		NAME OF CEMETERY OR CREMATORY <u>HOLY CROSS</u>		LOCATION (City, town, or county) (State) <u>A.A. County Md.</u>	
24. REC'D BY REGISTRAR DATE <u>Jan. 24, 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Geo. S. McEffer</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. H. Fleming</u>		ADDRESS <u>1426 Light St.</u>	

VS AISC 1-55 10M

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly must be detached for use as a burial transit permit.

# CERTIFICATE OF DEATH

209

1-2-11-11

1. DECEASED'S NAME (Last, first, middle)

2. SEX

3. DATE OF BIRTH

4. PLACE OF BIRTH

5. MEDICAL CERTIFICATION

BUREAU V. S.

JAN 25 1956

RECEIVED

355

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY <u>Baltimore</u> MARYLAND			STATE <u>Maryland</u> COUNTY		
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort Howard</u>			CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		
TOWN <u>Fort Howard</u>			TOWN <u>Baltimore</u>		
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>			STREET ADDRESS (If rural give location) <u>740 E. Fort Avenue</u>		
3. NAME OF DECEASED: (First) (Middle) (Last) <u>ANDREW J. REILLY</u>			4. DATE (Month) (Day) (Year) OF DEATH: <u>January 21, 1956</u>		
5. SEX: <u>MALE</u>	6. COLOR OR RACE: <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH: <u>January 3, 1892</u>		
9. AGE last birthday: <u>64</u> yrs.			10. IF UNDER 1 YEAR: Months Days Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Engineering</u>			10B. KIND OF BUSINESS OR INDUSTRY:		
11. BIRTHPLACE (State or foreign country): <u>Massachusetts</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME: <u>Unknown</u>			14. MOTHER'S MAIDEN NAME: <u>Unknown</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): <u>Yes</u> <u>WW-1</u>			16. SOCIAL SECURITY NO. <u>212-01-2689</u>		
17. INFORMANT & ADDRESS: <u>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</u>					

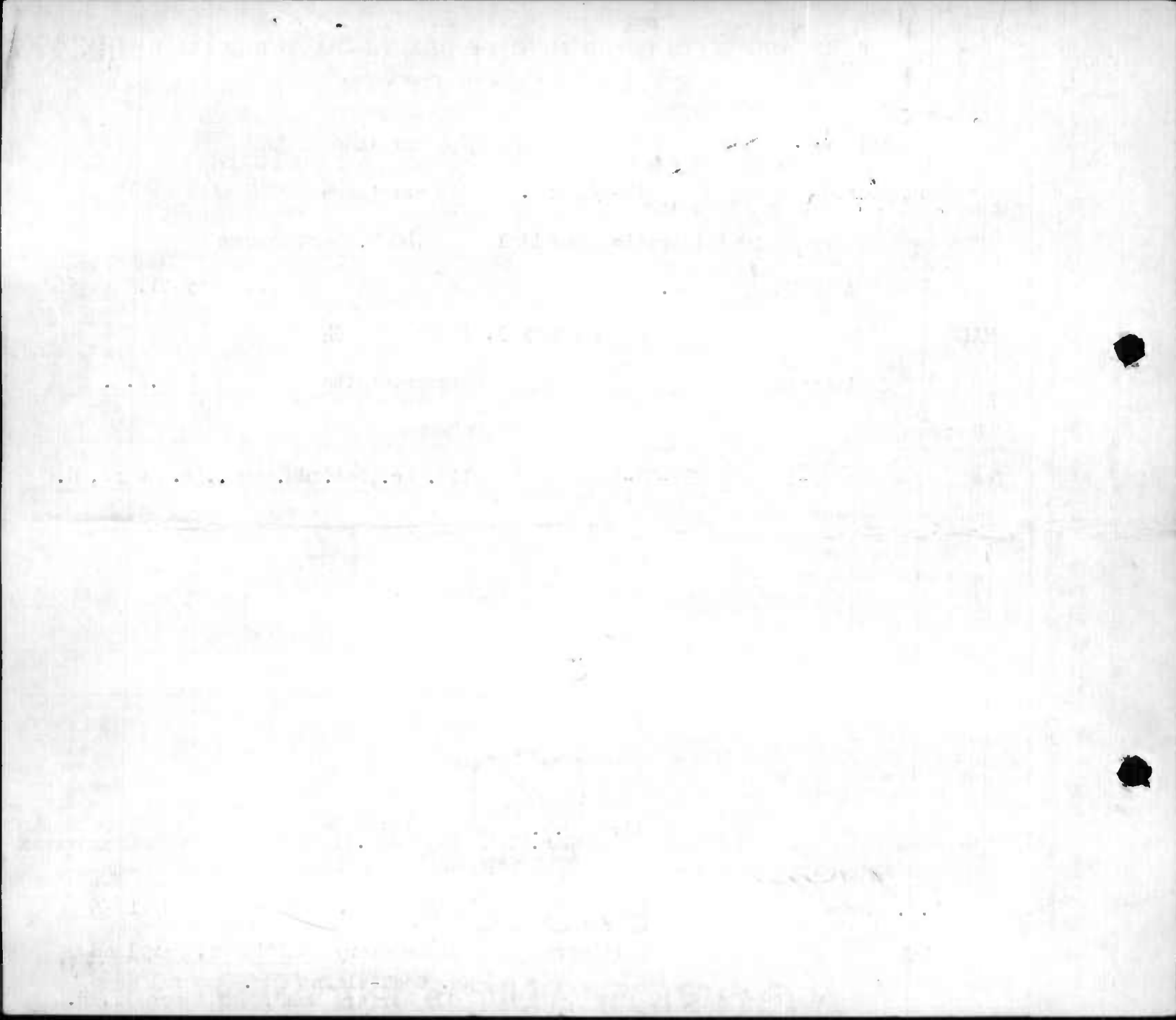
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
(A) IMMEDIATE CAUSE <u>CONGESTIVE HEART FAILURE</u>		
(B) ANTECEDENT CAUSE (S) <u>PULMONARY EMPHYSEMA</u>		UNKNOWN
(C) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Jan. 20, 1956</u> , to <u>Jan. 21, 1956</u> , that I last saw the deceased <u>alive on Jan. 20, 1956</u> , and that death occurred at <u>12:00 P.M.</u> , from the causes and on the date stated above.		SIGNATURE <u>D.D. Marks</u>		ADDRESS <u>M. D. Fort Howard, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1-24-56</u>		LOCATION (City, town, or county) (State) <u>Baltimore National Cemetery Baltimore, Maryland</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/24/56</u>		REGISTRAR'S SIGNATURE <u>A.W. Hedrick</u>		24. FUNERAL DIRECTOR, ADDRESS <u>Wm. Cook-Blight Inc. Funeral Home 6009 Harford Road, Baltimore 14, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00348

356

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort Howard</u>		<u>50 days</u>		TOWN <u>Baltimore</u>		<u>3401-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1204 Rueckert Ave., Balto 14, Md.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>JOHN C RHODES</u>				<u>January 15 19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Married</u>	<u>11/30/92</u>	<u>63</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Bookkeeper</u>		<u>Bank</u>		<u>Baltimore, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles M. Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Emma V. Dorsey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>Yes</u> <u>WWI</u>				<u>Unknown</u>		<u>Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.</u>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
IMMEDIATE CAUSE (A) <u>ADRENAL CORTICAL HYPOFUNCTION</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
ANTECEDENT CAUSE(S) DUE TO (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO							
<u>Other Significant cond. 1. Arteriosclerotic cardio-vascular disease 2. Rheumatoid arthritis. 3. Pneumonitis, left lung 4. Gastrointestinal hemorrhage.</u>						1. <u>1 1/2 yrs</u> 2. <u>16 yrs</u> 3. <u>3 days</u> 4. <u>1 day</u>	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>November 26 19 56</u> to <u>January 15 19 56</u> and that death occurred at <u>1:05 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>William M. Lavette M.D.</u>				ADDRESS (Street, city, town, state) <u>Veterans Administration Hosp. Ft. Howard, Md.</u>			
WILLIAM LAVETTE, M. D.				DATE SIGNED <u>1/15/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>1-18-56</u>		<u>Baltimore National</u>		<u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>Jan. 16, 1956</u>		<u>Lawson L. Farley</u>		<u>William Cook, Blight, Inc.</u>		<u>6009 Harford Rd., Balto., Md.</u>	

# CERTIFICATE OF DEATH

BUREAU OF STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

Reg. Dist. No.

LOCAL JURISDICTION, HOUSE OF COMMONS

NAME OF DECEASED  
AGE  
SEX  
RACE  
TALL  
WEIGHT  
BORN  
DIED

RESIDENCE  
CITY  
COUNTY  
STATE

DATE OF DEATH  
PLACE OF DEATH  
CAUSE OF DEATH

TO WHOM ISSUED  
BY WHOM ISSUED  
DATE OF ISSUANCE

REMARKS  
SIGNATURE OF REGISTRAR  
DATE OF SIGNATURE

REMARKS  
SIGNATURE OF REGISTRAR  
DATE OF SIGNATURE

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SIGNATURE OF REGISTRAR  
DATE OF SIGNATURE

BUREAU V. M.

JAN 17 1956

RECEIVED

NOTIFICATION

DATE OF DEATH

REMARKS



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00349

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

357

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town) <b>FORT HOWARD</b>		LENGTH OF STAY (in this place) <b>7 DAYS</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>BALTIMORE</b>		TOWN <b>BALTIMORE</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>1803 WHITMORE AVENUE</b>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <b>JAMES M. RIGNEY</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>JANUARY 13 19 56</b>			
<b>5. SEX</b> <b>Male</b>	<b>6. COLOR OR RACE</b> <b>White</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>Single</b>	<b>8. DATE OF BIRTH</b> <b>April 19, 1928</b>		<b>9. AGE last birthday</b> <b>27</b> yrs.	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Laborer-warehouse</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Can company</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U. S. A.</b>	
<b>13. FATHER'S NAME</b> <b>George E. Rigney</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Cecelia Clark</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>218-22-6627</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Clin. Rec., Vet. Adm. Hosp., Fort Howard, Md.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>204.0 IMMEDIATE CAUSE (A)</b> <b>ACUTE LYMPHATIC LEUKEMIA</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 WEEKS</b>	
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <b>DUE TO</b>							
<b>(C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)</b>		<b>21e. INJURY OCCURRED</b> White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> el work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that</b> <b>VA</b> <b>Jan. 6, 1956</b> <b>Jan. 13, 1956</b> <b>the deceased was</b> <b>attended by</b> <b>Howard C. Kramer, M.D.</b> <b>and that death occurred at</b> <b>9:25 PM</b> <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <b>HOWARD C. KRAMER, M.D.</b>				<b>ADDRESS</b> (Street, city, town, state) <b>VAH, FORT HOWARD, MARYLAND</b>			
<b>DATE SIGNED</b> <b>1/14/56</b>							
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Burial</b>		<b>DATE THEREOF</b> <b>1-17-56</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>New Cathedral Cemetery</b>		<b>LOCATION (City, town, or county)</b> <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <b>Jan. 16, 1956</b>		<b>REGISTRAR'S SIGNATURE</b> <b>Amos L. Fisher</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Wm. Cook-Blight, Inc.</b>		<b>ADDRESS</b> <b>6009 Harford Rd., Balto. Md.</b>	

# CERTIFICATE OF DEATH

FILE NO.

A. NAME OF DECEASED (Print or Write)

B. SEX (Male or Female)

C. AGE (Years, Months, Days)

D. DATE OF BIRTH (Month, Day, Year)

E. PLACE OF BIRTH (City, Town, Village, or State)

F. OCCUPATION (Print or Write)

G. CAUSE OF DEATH (Print or Write)

H. PLACE OF DEATH (City, Town, Village, or State)

I. DATE OF DEATH (Month, Day, Year)

J. TIME OF DEATH (Hour, Minute)

K. SIGNATURE OF DECEASED (Print or Write)

L. SIGNATURE OF WITNESSES (Print or Write)

M. SIGNATURE OF PHYSICIAN (Print or Write)

N. SIGNATURE OF CLERK (Print or Write)

O. SIGNATURE OF JURY (Print or Write)

P. SIGNATURE OF JUDGE (Print or Write)

Q. SIGNATURE OF SHERIFF (Print or Write)

R. SIGNATURE OF CORONER (Print or Write)

S. SIGNATURE OF JURY (Print or Write)

T. SIGNATURE OF JUDGE (Print or Write)

U. SIGNATURE OF SHERIFF (Print or Write)

V. SIGNATURE OF CORONER (Print or Write)

W. SIGNATURE OF JURY (Print or Write)

X. SIGNATURE OF JUDGE (Print or Write)

Y. SIGNATURE OF SHERIFF (Print or Write)

Z. SIGNATURE OF CORONER (Print or Write)

AA. SIGNATURE OF JURY (Print or Write)

AB. SIGNATURE OF JUDGE (Print or Write)

AC. SIGNATURE OF SHERIFF (Print or Write)

AD. SIGNATURE OF CORONER (Print or Write)

AE. SIGNATURE OF JURY (Print or Write)

AF. SIGNATURE OF JUDGE (Print or Write)

AG. SIGNATURE OF SHERIFF (Print or Write)

AH. SIGNATURE OF CORONER (Print or Write)

AI. SIGNATURE OF JURY (Print or Write)

AJ. SIGNATURE OF JUDGE (Print or Write)

AK. SIGNATURE OF SHERIFF (Print or Write)

AL. SIGNATURE OF CORONER (Print or Write)

AM. SIGNATURE OF JURY (Print or Write)

AN. SIGNATURE OF JUDGE (Print or Write)

AO. SIGNATURE OF SHERIFF (Print or Write)

AP. SIGNATURE OF CORONER (Print or Write)

AQ. SIGNATURE OF JURY (Print or Write)

AR. SIGNATURE OF JUDGE (Print or Write)

AS. SIGNATURE OF SHERIFF (Print or Write)

AT. SIGNATURE OF CORONER (Print or Write)

AU. SIGNATURE OF JURY (Print or Write)

AV. SIGNATURE OF JUDGE (Print or Write)

AW. SIGNATURE OF SHERIFF (Print or Write)

AX. SIGNATURE OF CORONER (Print or Write)

BUREAU V. S.

JAN 17 1956

RECEIVED

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Catonsville</u>		1yr. 4mth. 21 dys.		OR TOWN <u>Baltimore City</u>		3421-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 SPRING GROVE STATE HOSP:</u>				STREET ADDRESS (If rural give location) <u>20 N. Calhoun St. - Balto., Md.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)		OF DEATH: Jan. 22,		19 56	
5. SEX: female		6. COLOR OR RACE: white		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Widowed		8. DATE OF BIRTH: Sept. 21 ?	
9. AGE last birthday: 70 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): unknown		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): unknown	
13. FATHER'S NAME: unknown		14. MOTHER'S MAIDEN NAME: unknown		17. INFORMANT & ADDRESS: Sprigg Grove Hospital records		12. CITIZEN OF WHAT COUNTRY?	
15. WAR DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): unknown		16. SOCIAL SECURITY NO. unknown		18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		260X IMMEDIATE CAUSE (A) Cerebral vascular accident		DUE TO		one day	
ANTECEDENT CAUSE (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(B) Diabetes Mellitus		DUE TO		years	
(C) Generalized arteriosclerosis						years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: 0		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from 9-4, 1953, to Jan. 22 1956, that I last saw the deceased alive on Jan. 22, 1956, and that death occurred at 10:30 AM, from the causes and on the date stated above.							
SIGNATURE <u>Hella Wachter</u>		ADDRESS <u>SPRING GROVE STATE HOSPITAL</u>		DATE SIGNED <u>1-25-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <u>1/30/56</u>		NAME OF CEMETERY OR CREMATORY <u>U. of Md. Med. School</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>13 15 1956</u>		REGISTRAR'S SIGNATURE <u>J. E. Harvey</u>		24. FUNERAL DIRECTOR		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

~~File~~

16/12

164 cm.

BUREAU V. S.

FEB 16 1956

RECEIVED

Item 18 Form 1172 2-17-50 ans

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

Reg. Dist.

No. 44

## I. PLACE OF DEATH:

COUNTY **Baltimore**

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) **Rural Baltimore**

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS **Bethlehem Steel Dispensary**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE **Maryland** COUNTY **Baltimore**CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN **Baltimore**STREET ADDRESS (If rural, give location) **605 E. Arlington Avenue**

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

**Franklin****W.****Roberts**

4. DATE

(Month)

(Day)

(Year)

OF DEATH

**1****20****1956**

## 5. SEX:

## 6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): **Married**

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR

IF UNDER 24 HRS.

**Male****White****Sept. 9, 1898****57**

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): **Shipping Clerk - Steel**

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): **Berkley, Va.**12. CITIZEN OF WHAT COUNTRY? **U.S. A.**

## 13. FATHER'S NAME:

**H. P. Roberts**

## 14. MOTHER'S MAIDEN NAME:

**Annie Nora Pierce**15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) **Yes W W I**

## 16. SOCIAL SECURITY No.:

**Yes**

## 17. INFORMANT &amp; ADDRESS:

**Mrs. Mildred Lee Roberts 605 E. Arlington Ave.**

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause

(a).....

DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b).....

DUE TO

(c).....

**Calcific Aortic Stenosis, Marked**

INTERVAL BETWEEN ONSET AND DEATH

## II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

**Fractured Right Ankle**

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDING OF OPERATION:

## 20. AUTOPSY?

Yes ☒ No ☐21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town)

(County)

(State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY

21e. INJURY OCCURRED While at Not while work ☐ at work ☐

## 21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☐, Inquiry ☐, and find that death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE

*Frank P. Roberts*CHIEF MEDICAL EXAMINER ☐ DATE SIGNED  
DEPUTY MEDICAL EXAMINER ☐  
ASSISTANT MEDICAL EXAM. ☒

M. D.

**1/20/56**

## 23. BURIAL, CREMATION, REMOVAL (Specify):

**Burial**

## DATE THEREOF

**1/23/56**

## NAME OF CEMETERY OR CREMATORY

**Mt. Olivet Cemetery**

## LOCATION (City, town, or county)

**Frederick, Md.**

(State)

DATE REC'D BY LOCAL REG.

## REGISTRAR'S SIGNATURE

*G. W. Hedrick*

## 24. FUNERAL DIRECTOR

**John A. Moran - 3000 E. Baltimore St.**

## ADDRESS



DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

STATE OF NEW YORK

County of ...

City of ...

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00351

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## CERTIFICATE OF DEATH

Item 2, Film 192 1-31-56 et

Reg. Dist. No. 37

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Cockeysville</u>		<u>26 months</u>		TOWN <u>Cockeysville</u>		<u>Lansdowne 51</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Masonic Home of Md.</u>				STREET ADDRESS <u>2610 Brawn Avenue</u> (If rural give location) <u>Maryland</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Rachel Rockwell</u>				<u>Jan 25 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widow</u>	<u>Oct. 25 1896</u>	<u>79</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>None</u>		<u>Lansdowne, Md.</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis Cash</u>				14. MOTHER'S MAIDEN NAME <u>Hennetta Finberg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
				<u>Thomas Dennis, Masonic Home</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
IMMEDIATE CAUSE (A) <u>arteriosclerotic cardiovascular disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>			
ANTECEDENT CAUSE(S) DUE TO (B)				CERTIFICATION APPROVED BY <u>Paul H. Kees</u> M.D.			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>fracture left hip</u>				CHIEF OR A <u>fracture</u> <u>fracture</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>1/15/56</u>		19b. MAJOR FINDINGS OF OPERATION <u>fractured hip</u>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street/office bldg, etc.) <u>home</u>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <u>Masonic Home</u> <u>Balto</u> <u>Md</u>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>1/14/56</u> <u>9 P.M.</u>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <u>at work</u>		21f. HOW DID INJURY OCCUR? <u>While walking in room, fell to floor</u>			
<b>22. I hereby certify that I attended the deceased from</b> <u>Jan 13 1956</u> , <b>to</b> <u>Jan 25 1956</u> , <b>that I last saw the deceased alive on</b> <u>Jan 24 1956</u> , <b>and that death occurred at</b> <u>5:45</u> <b>M.</b> , <b>from the causes and on the date stated above.</b>							
SIGNATURE <u>Walter T. Kees</u>				ADDRESS (Street, city, town, state) <u>Cockeysville Md</u>			
				DATE SIGNED <u>1/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>1/27/56</u>		NAME OF CEMETERY OR CREMATORY <u>Lorraine Cemetery</u>		LOCATION (City, town, or county) (State) <u>Woodlawn Maryland</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Gene MacRae</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm Cook Inc</u>		ADDRESS <u>1317 E. Paul St</u>	
DATE <u>Jan. 26, 1956</u>							

# CERTIFICATE OF DEATH

322

Reg. Dist. No.

1. DECEASED'S RESIDENCE HOME OR BUSINESS

2. PLACE OF DEATH

3. DECEASED'S AGE

4. SEX

5. OCCUPATION

6. DECEASED'S RACE

7. DECEASED'S COLOR

8. DECEASED'S RELIGION

9. DECEASED'S MARITAL STATUS

10. DECEASED'S EDUCATION

11. DECEASED'S BIRTH DATE

12. DECEASED'S BIRTH PLACE

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128. DECEASED'S BIRTH PLACE

BUREAU V. S.

JAN 26 1956

RECEIVED

NOTIFICATION OF DEATH TO BE FURNISHED TO THE LOCAL HEALTH DEPARTMENT BY THE REGISTRAR OF DEATHS, COUNTY OF BALTIMORE, MARYLAND, ON THE DATE OF DEATH.

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00352

361

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>MARYLAND</u>		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Catonsville</u>				TOWN <u>Baltimore</u>		<u>3Y01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Daughters of the Eucharist</u>				STREET ADDRESS (If rural give location)			
<u>Recedo Knoll, 601 Maiden Choice Lane</u>				<u>1829 N. Washington Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>LULA</u> <u>ROSAZZA</u>				<u>Jan. 3, 1956</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>female</u>	<u>white</u>	<u>single</u>	<u>about 1885</u>	<u>about 70 yrs.</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>never employed</u>				<u>Baltimore, Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>John E. Rosazza</u>				14. MOTHER'S MAIDEN NAME <u>Mary L. ---</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>---</u>		<u>---</u>		<u>Marion A. Figinski, 351 Bldg. Equitable</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
430.1 IMMEDIATE CAUSE (A) <u>Cranial Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Cardio-Vascular Disease &amp; Hypertension</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> M. <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1913</u> , <u>1953</u> , to <u>1956</u> , that I last saw the deceased alive on <u>12/30</u> , <u>1955</u> , and that death occurred at <u>9:45 P.</u> M., from the causes and on the date stated above.							
SIGNATURE <u>Elmer W. Johnson</u>				ADDRESS (Street, city, town, state) <u>3432 Redwood Ave</u>		DATE SIGNED <u>1/5/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		DATE THEREOF <u>1/7/56</u>		NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cemetery</u>		LOCATION (City, town, or county) <u>Baltimore, Maryland</u>	
24. REC'D BY REGISTRAR <u>JAN 6 1956</u>		REGISTRAR'S SIGNATURE <u>F. E. Harvey</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. Cook Inc</u> ADDRESS <u>1217 St. Paul Street</u>			

RECEIVED

**INSTRUCTIONS**

**1** **TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

**2** **TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00353

291

# CERTIFICATE OF DEATH

Reg. Dist. No. 41

<b>1. PLACE OF DEATH</b>		<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>	
COUNTY <u>BALTO.</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>BALTO</u>
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK</u>	LENGTH OF STAY (in this place) <u>2 YRS</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>DUNDALK 22</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>102 VENTNOR TERRACE</u>		STREET ADDRESS (If rural give location) <u>102 VENTNOR TERRACE</u>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>MARY HOLOTA ROSMUS</u>		<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>1-31-56</u>	
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>W.</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>WIDOWED</u>	<b>8. DATE OF BIRTH</b> <u>OCT. 23, 1890</u>
<b>9. AGE last birthday</b> <u>65</u> yrs.		<b>10. IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u></u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>CZECHOSLOVAKI</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>MICHAEL HOLOTA</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>MARY (?)</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <u>NO</u>		<b>16. SOCIAL SECURITY NO.</b> <u>NONE</u>	
<b>17. INFORMANT &amp; ADDRESS</b> <u>JEAN C. MILLER DUNDALK</u>		<b>18. MEDICAL CERTIFICATION</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>420.1 IMMEDIATE CAUSE</b> (A) <u>Cerebral Occlusion</u>		<u>1 hour</u>	
<b>ANTECEDENT CAUSE(S)</b> DUE TO (B) <u></u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> DUE TO (C) <u></u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Diabetes Mellitus</u>		<u>2 yrs.</u>	
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>	
<b>21a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>	
<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)		<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)	
<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I attended the deceased from</b> <u>1-28</u> , 19 <u>56</u> , <b>to</b> <u>1-31</u> , 19 <u>56</u> , <b>that I last saw the deceased alive on</b> <u>1-28</u> , 19 <u>56</u> , <b>and that death occurred at</b> <u>10:50 A</u> , <b>from the causes and on the date stated above.</b>			
<b>SIGNATURE</b> <u>Jack Challen</u>		<b>DATE SIGNED</b> <u>1-31-56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>LLOYD</u>	
<b>DATE THEREOF</b> <u>2-4-56</u>		<b>LOCATION (City, town, or county) (State)</b> <u>EVANSBURG - PENNA</u>	
<b>24. REC'D BY REGISTRAR</b> <u>William M. Kelly</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>William M. Kelly</u>	
<b>DATE</b> <u>Feb 2-1956</u>		<b>ADDRESS</b> <u>102 VENTNOR TERRACE, DUNDALK, MD</u>	



00333

BALTIMORE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

## CERTIFICATE OF DEATH

241

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. SIGNATURE OF DECEASED

10. SIGNATURE OF WITNESSES

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF CLERK

13. SIGNATURE OF JURY

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF DISTRICT ATTORNEY

18. SIGNATURE OF COUNTY CLERK

19. SIGNATURE OF CITY CLERK

20. SIGNATURE OF VICE MAYOR

21. SIGNATURE OF MAYOR

22. SIGNATURE OF COMMISSIONER

23. SIGNATURE OF DEPUTY COMMISSIONER

24. SIGNATURE OF ASSISTANT COMMISSIONER

25. SIGNATURE OF CHIEF CLERK

26. SIGNATURE OF CLERK

27. SIGNATURE OF JURY

28. SIGNATURE OF JUDGE

29. SIGNATURE OF SHERIFF

30. SIGNATURE OF CORONER

31. SIGNATURE OF DISTRICT ATTORNEY

32. SIGNATURE OF COUNTY CLERK

33. SIGNATURE OF CITY CLERK

34. SIGNATURE OF VICE MAYOR

35. SIGNATURE OF MAYOR

36. SIGNATURE OF COMMISSIONER

37. SIGNATURE OF DEPUTY COMMISSIONER

38. SIGNATURE OF ASSISTANT COMMISSIONER

39. SIGNATURE OF CHIEF CLERK

40. SIGNATURE OF CLERK

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42. SIGNATURE OF JUDGE

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156. SIGNATURE OF CORONER

157. SIGNATURE OF DISTRICT ATTORNEY

158. SIGNATURE OF COUNTY CLERK

159. SIGNATURE OF CITY CLERK

160. SIGNATURE OF VICE MAYOR

161. SIGNATURE OF MAYOR

162. SIGNATURE OF COMMISSIONER

163. SIGNATURE OF DEPUTY COMMISSIONER

164. SIGNATURE OF ASSISTANT COMMISSIONER

165. SIGNATURE OF CHIEF CLERK

166. SIGNATURE OF CLERK

167. SIGNATURE OF JURY

168. SIGNATURE OF JUDGE

169. SIGNATURE OF SHERIFF

170. SIGNATURE OF CORONER

171. SIGNATURE OF DISTRICT ATTORNEY

172. SIGNATURE OF COUNTY CLERK

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210. SIGNATURE OF JUDGE

211. SIGNATURE OF SHERIFF

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220. SIGNATURE OF ASSISTANT COMMISSIONER

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256. SIGNATURE OF COUNTY CLERK

257. SIGNATURE OF CITY CLERK

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260. SIGNATURE OF COMMISSIONER

261. SIGNATURE OF DEPUTY COMMISSIONER

262. SIGNATURE OF ASSISTANT COMMISSIONER

263. SIGNATURE OF CHIEF CLERK

264. SIGNATURE OF CLERK

265. SIGNATURE OF JURY

266. SIGNATURE OF JUDGE

267. SIGNATURE OF SHERIFF

268. SIGNATURE OF CORONER

269. SIGNATURE OF DISTRICT ATTORNEY

270. SIGNATURE OF COUNTY CLERK

271. SIGNATURE OF CITY CLERK

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273. SIGNATURE OF MAYOR

274. SIGNATURE OF COMMISSIONER

275. SIGNATURE OF DEPUTY COMMISSIONER

276. SIGNATURE OF ASSISTANT COMMISSIONER

277. SIGNATURE OF CHIEF CLERK

278. SIGNATURE OF CLERK

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280. SIGNATURE OF JUDGE

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283. SIGNATURE OF DISTRICT ATTORNEY

284. SIGNATURE OF COUNTY CLERK

285. SIGNATURE OF CITY CLERK

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287. SIGNATURE OF MAYOR

288. SIGNATURE OF COMMISSIONER

289. SIGNATURE OF DEPUTY COMMISSIONER

290. SIGNATURE OF ASSISTANT COMMISSIONER

291. SIGNATURE OF CHIEF CLERK

292. SIGNATURE OF CLERK



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00354

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <b>TOWSON</b> <b>BALTIMORE</b> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <b>MARYLAND</b> COUNTY <b>BALTIMORE</b>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) TOWN <b>TOWSON</b>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>TOWSON (4)</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS -		STREET ADDRESS (If rural, give location) <b>602 E. JOPPA ROAD</b>	
3. NAME OF DECEASED (Type or Print)	(First) <b>HERMAN</b>	(Middle) <b>LEE</b>	(Last) <b>ROWELL</b>
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>AUG 13, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SAFETY ENGINEER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>BENDIX RADIO</b>	9. AGE last birthday <b>60</b> yrs.
11. BIRTHPLACE (State or foreign country) <b>GARYSBURG, N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ALBERT ROWELL</b>		14. MOTHER'S MAIDEN NAME <b>DORA JORDAN</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <b>YES</b> <b>WW II</b>		16. SOCIAL SECURITY No. <b>241-38-2051</b>	
17. INFORMANT AND ADDRESS <b>MRS. ELIZABETH ROWELL, SAME</b>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a) **MYOCARDIAL INFARCTION**INTERVAL BETWEEN ONSET AND DEATH  
**30 MINUTES**

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b) **CORONARY OCCLUSION****30 MINUTES**(c) **ARTERIOSCLEROTIC CORONARY DISEASE****5 YEARS**

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT (Specify) <b>SUICIDE</b> <b>HOMICIDE</b>	PLACE (Home, farm, factory, street, OF office bldg., etc.) <b>INJURY</b>	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from **2-28-55**, to **1-16-56**, that I last saw the deceasedalive on **1-14-56**, and that death occurred at **9:00 A.M.**, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>	DATE THEREOF <b>JAN. 19, 1956</b>	NAME OF CEMETERY OR CREMATORY <b>ARLINGTON NATL. CEM.</b>	LOCATION (City, town, or county) <b>ARLINGTON, VIRGINIA</b>	(State)
DATE REC'D BY LOCAL REG. <b>JAN. 19, 1956</b>	REGISTRAR'S SIGNATURE <b>Mabel C. Gray</b>	FUNERAL DIRECTOR <b>John Burns &amp; Son, Towson, Md.</b>		ADDRESS

BUREAU V. S.

JAN 20 1956

RECEIVED

PLEASE TYPE OR WITH PERMANENT BLACK OR BLUE-BLACK INK—DO NOT USE A BALL POINT PEN.  
Every item of information s/c carefully supplied. Physicians: please write the causes of death clearly and let  
THIS CERTIFICATE MUST BE WITH THE BUREAU OF VITAL RECORDS WITHIN THREE (3) DAYS AFTER

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

363

00355

1. NAME OF DECEASED (Type or Print)			DELIA A. RUTHERFORD			2. DATE OF DEATH			Jan. 13, 1956						
3. PLACE OF DEATH: A. Baltimore City, Maryland Baltimore County						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore									
B. FULL NAME OF HOSPITAL OR INSTITUTION Stoneleigh 1010 Overbrook Road						C. CITY OR TOWN (If outside corporate limits, write RURAL and give township) Stoneleigh									
c. Length of stay in Baltimore 00 Yrs. Mos. Days						D. STREET ADDRESS (If rural, give location) 1010 Overbrook Road									
5. SEX female		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) widowed		8. DATE OF BIRTH Aug. 11, 1870		9. AGE (in years last birthday) 85		10 Under 1 Year Months: Days		11 Under 24 Hours Hours: Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10B. KIND OF BUSINESS OR INDUSTRY at home				11. BIRTHPLACE (State or foreign country) Monroe Co., West Virginia				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME ----- Fisher						14. MOTHER'S MAIDEN NAME -----									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) -----						16. SOCIAL SECURITY NO. -----		17. INFORMANT Lillie P. Eads, 1010 Overbrook Rd.				ADDRESS			

18. CAUSE OF DEATH										INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 260X Uremia DUE TO Dissecting Aneurysm										24 hours 15 yrs			
260X ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (B) Sanitary - Anterior										10 yrs			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.													
IF OPERATION WAS RELATED TO CAUSE OF DEATH, ENTER IN PART I OR PART II				19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20. AUTOPSY? YES <input type="checkbox"/> - NO <input type="checkbox"/>	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from Jan. 13 - 56 19 to Jan. 13 - 56 19, that (I) (we) last saw the deceased alive on Jan. 11 - 56 19, and that death occurred at 6:15 A. m., from the causes and on the date stated above.													
23A. SIGNATURE A. H. Harrison						23B. ADDRESS 1710 E. 33 St				23C. DATE SIGNED 1-13-56			
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				24A. BURIAL, CREMATION, REMOVAL (Specify) removal				24B. DATE 1/13/56		24C. NAME OF CEMETERY OR CREMATORY Wildwood Cemetery		24D. LOCATION (City, town, or county) (State) Beckley, West Virginia	
DATE RECEIVED BY LOCAL REGISTRAR 1/13/56				REGISTRAR'S SIGNATURE A. H. Harrison				25. FUNERAL DIRECTOR New People Inc.				ADDRESS 1217 St. Paul Street	

1. The first part of the report is a summary of the work done during the period covered by the report.

2. The second part of the report is a detailed account of the work done during the period covered by the report.

3. The third part of the report is a summary of the work done during the period covered by the report.

4. The fourth part of the report is a summary of the work done during the period covered by the report.

5. The fifth part of the report is a summary of the work done during the period covered by the report.

6. The sixth part of the report is a summary of the work done during the period covered by the report.

7. The seventh part of the report is a summary of the work done during the period covered by the report.

8. The eighth part of the report is a summary of the work done during the period covered by the report.

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10. The tenth part of the report is a summary of the work done during the period covered by the report.

11. The eleventh part of the report is a summary of the work done during the period covered by the report.

12. The twelfth part of the report is a summary of the work done during the period covered by the report.

13. The thirteenth part of the report is a summary of the work done during the period covered by the report.

14. The fourteenth part of the report is a summary of the work done during the period covered by the report.

15. The fifteenth part of the report is a summary of the work done during the period covered by the report.

16. The sixteenth part of the report is a summary of the work done during the period covered by the report.

17. The seventeenth part of the report is a summary of the work done during the period covered by the report.

18. The eighteenth part of the report is a summary of the work done during the period covered by the report.

19. The nineteenth part of the report is a summary of the work done during the period covered by the report.

20. The twentieth part of the report is a summary of the work done during the period covered by the report.

21. The twenty-first part of the report is a summary of the work done during the period covered by the report.

22. The twenty-second part of the report is a summary of the work done during the period covered by the report.

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00356

264

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore County</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Riderwood</u>		<u>15 days</u>		TOWN <u>Baltimore, Maryland</u>		<u>3601-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorensen Nursing Home</u> <u>7912 Ruxway Road</u>				STREET ADDRESS (If rural give location) <u>2813 North Calvert Street</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Lillian</u> (First) <u>Schaeffer</u> (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Jan 4th, 1956</u>			
<b>5. SEX</b> <u>female</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>widowed</u>	<b>8. DATE OF BIRTH</b> <u>Oct. 15, 1897</u>	<b>9. AGE last birthday</b> <u>58</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>unknown</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>unknown</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>unknown</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <u>unknown</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Sorensen Nursing Home</u>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>441X</u> IMMEDIATE CAUSE (A) <u>Acute embolism pulmonary, cerebral</u>						<u>24 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension arterial malignant</u>						<u>3 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Fracture right forearm, ecchymosis</u>						<u>1 month</u>	
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Myocarditis chronic with hypertrophy</u>						<u>5 years</u>	
<b>19a. DATE OF OPERATION</b> <u>12-15-1955</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Application of cast right arm</u>					
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b> <u>home</u>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b> <u>home Baltimore Md.</u>		<b>CERTIFICATION APPROVED</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b> <u>unknown Dec 15, 1955</u>		<b>21e. INJURY OCCURRED While at work Not while at work</b> <input type="checkbox"/> <input checked="" type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b> <u>Accidental fall at home.</u>		<b>CHIEF OR ASST. MEDICAL EXAMINER.</b>	
<b>22. I hereby certify that I attended the deceased from <u>Dec 21, 1955</u>, to <u>Jan. 4th, 1956</u>, that I last saw the deceased alive on <u>Dec 27, 1955</u>, and that death occurred at <u>6:45 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Anna Graham Martin</u> M.D.				<b>DATE SIGNED</b> <u>516 Cathedral St I-5-1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>burial</u>		<b>DATE THEREOF</b> <u>1/9/56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Druid Ridge Cemetery</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Pikesville, Maryland</u>	
<b>24. REC'D BY REGISTRAR</b> <u>IAN 10 1956</u>		<b>REGISTRAR'S SIGNATURE</b> <u>Mabel Gray</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Wm. Cook, Inc.</u>		<b>ADDRESS</b> <u>1217 St. Paul St.</u>	





PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 1800357

## 365 CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto.</u>		MARYLAND		STATE <u>New York</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Ruxton</u>				TOWN <u>Freeport, Long Island</u> <u>692-3</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorensen Nursing Home</u>				STREET ADDRESS (If rural give location) <u>11 Leonard Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>ELIZABETH SCHAPFER</u>				<u>Jan. 3, 19 56</u>			
5. SEX: <u>female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>widowed</u>		8. DATE OF BIRTH: <u>July 2, 1875</u>	
						9. AGE last birthday <u>80</u> yrs.	
						IF UNDER 1 YEAR Months Days	
						IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired housewife</u>				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Freeland</u>				14. MOTHER'S MAIDEN NAME: <u>Wilhelmina</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS: <u>Glyndon, Md. Mrs. Mary C. Gambrill - 128 Butler Rd., /</u>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>446X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Uremic coma</u>							
(B) <u>Nephritis - chronic interstitial</u>							
(C) <u>Arteriosclerosis - general</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>✓</u>				19B. MAJOR FINDINGS OF OPERATION: <u>✓</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work		21F. HOW DID INJURY OCCUR? <u>✓</u>			
22. I hereby certify that I attended the deceased from <u>10-1-1955</u> , to <u>1-3-1956</u> , that I last saw the deceased alive on <u>1-2-1956</u> , and that death occurred at <u>12:30 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Samuel H. Saffell</u>				DATE SIGNED <u>1-3-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				DATE THEREOF <u>1/5/56</u>		NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cem.</u>	
24. FUNERAL DIRECTOR <u>Wm. J. Tichauer &amp; Sons - Balt. 17, Md.</u>				LOCATION (City, town, or county) <u>Prince Frederick, Md.</u>		(State)	
DATE REC'D BY LOCAL REGISTRAR <u>1-5-56</u>				REGISTRAR'S SIGNATURE <u>Wm. J. Tichauer</u>			



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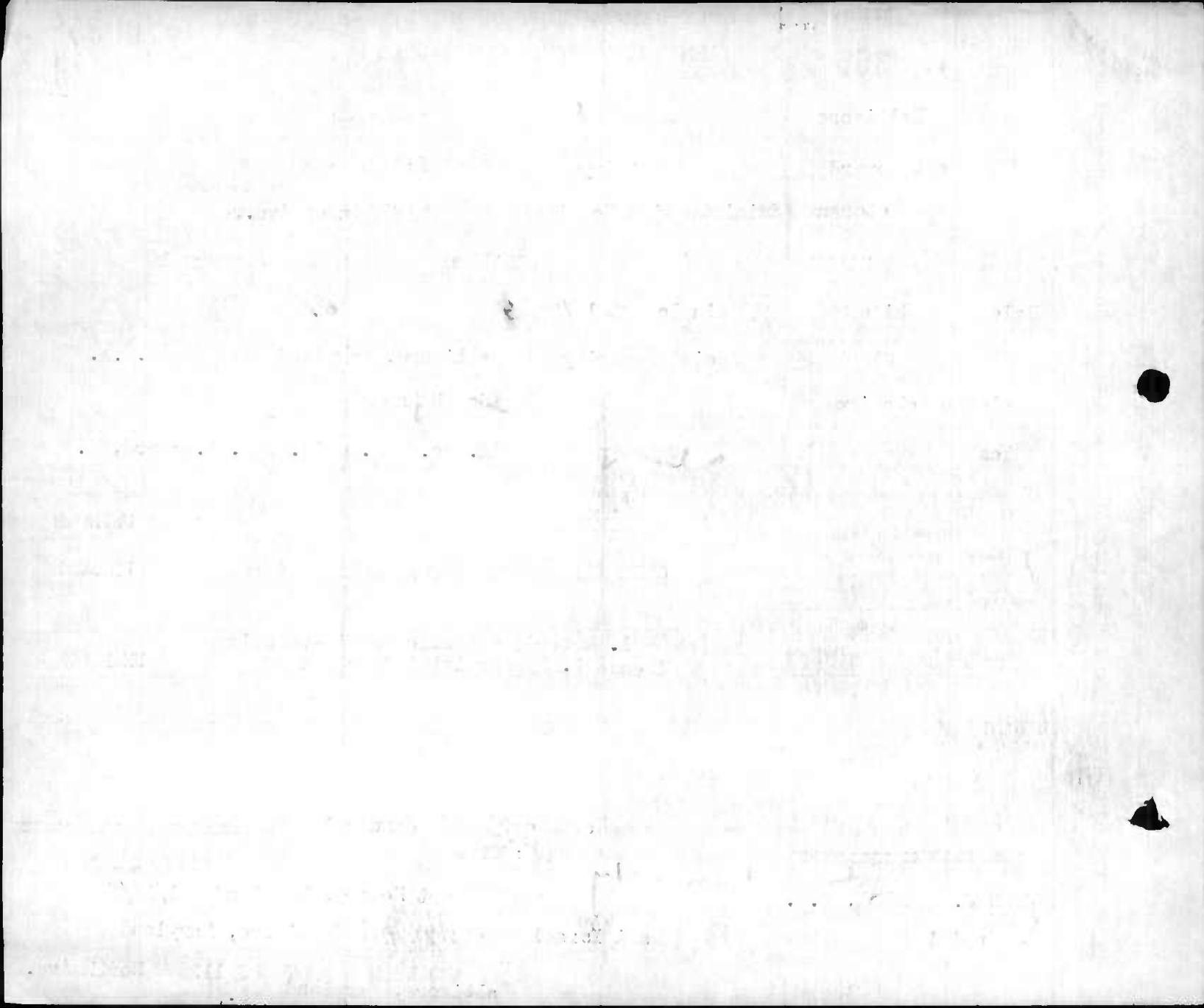
## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fort Howard</u>		LENGTH OF STAY (in this place) <u>52 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>		STREET ADDRESS (If rural give location) <u>1905 Linden Avenue</u>					
3. NAME OF DECEASED: (First) <u>HARRY</u> (Middle) <u>(NMI)</u> (Last) <u>SCHAPIRO</u>				4. DATE OF DEATH: (Month) <u>January</u> (Day) <u>16</u> (Year) <u>19 56</u>			
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE. MARRIED. WIDOWED. DIVORCED. (Specify) <u>Single</u>	8. DATE OF BIRTH: <u>12/22/94</u>	9. AGE last birthday <u>61</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Clerk</u>			10B. KIND OF BUSINESS OR INDUSTRY: <u>Social Security</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>Soleman Schapiro</u>				14. MOTHER'S MAIDEN NAME: <u>Ida (Unknown)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>Yes</u> <u>WWI</u>			16. SOCIAL SECURITY No. <u>Unknown</u>		17. INFORMANT & ADDRESS: <u>Clin. Rec. Vets. Admin. Hosp. Ft. Howard, Md.</u>		
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE			(A) <u>CEREBRAL HEMORRHAGE</u>				UNKNOWN
ANTECEDENT CAUSE (B)			DUE TO				
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			(B) <u>GENERALIZED ARTERIOSCLEROSIS</u>				UNKNOWN
			DUE TO				
			(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>1. Arteriosclerotic cardio-vascular disease 2. Myocardial infarction</u>							UNKNOWN
19A. DATE OF OPERATION:			19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY			21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		
22. I hereby certify that I attended the deceased from <u>November 25 1955</u> to <u>January 16 1956</u> , and that death occurred at <u>5:00 P. M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John J. Kennedy</u>			ADDRESS <u>M. D. VAH Fort Howard, Maryland</u>		DATE SIGNED <u>1/16/56</u>		
23. BURIAL. CREMATION. REMOVAL (SPECIFY) <u>Burial</u>			DATE THEREOF <u>Jan 17 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Bnai Israel Cemetery</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
DATE REC'D BY LOCAL REGISTRAR			REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS <u>SOL LEVINSON &amp; BROTHERS 1126 W North Ave. Baltimore, Maryland</u>		

MARGIN RESERVED FOR BINDER

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

100859

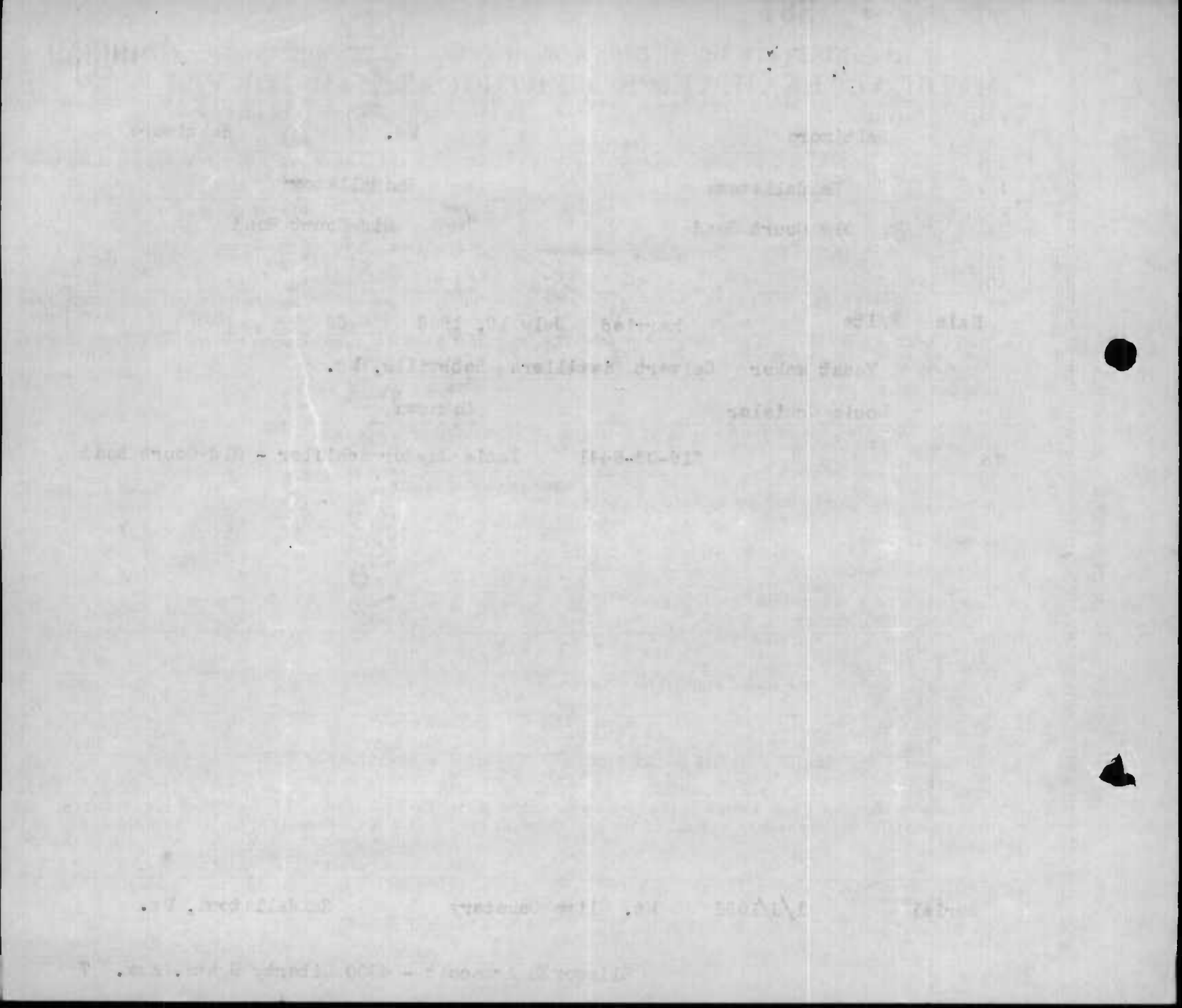
No. 31

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <b>Baltimore</b>	MARYLAND	STATE <b>Md.</b>	COUNTY <b>Baltimore</b>
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <b>Randallstown</b>		CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <b>Randallstown</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Old Court Road</b>		STREET ADDRESS (If rural, give location) <b>Old Court Road</b>	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <b>IRVIN</b>	(Middle) <b>ELMER</b>	(Last) <b>SCHISLER</b>	(Month) <b>JAN</b> (Day) <b>3</b> (Year) <b>1956</b>
5. SEX: <b>Male</b>	6. COLOR OR RACE: <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <b>Married</b>	8. DATE OF BIRTH: <b>July 12, 1886</b>
9. AGE last birthday: <b>69</b> yrs.		10. IF UNDER 1 YEAR: Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <b>Yeast maker</b>		10b. KIND OF BUSINESS OR INDUSTRY: <b>Calvert Distillers</b>	
11. BIRTHPLACE (State or foreign country): <b>Hebbville, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <b>Louis Schisler</b>		14. MOTHER'S MAIDEN NAME: <b>Unknown</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <b>No</b> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <b>216-03-8441</b>	
17. INFORMANT & ADDRESS: <b>Katie Snyder Schisler - Old Court Road</b>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		
(a) Immediate cause: <b>Suffocation by hanging &amp; second &amp; 3rd degree burns</b>		<b>10 min.</b>
(b) Antecedent cause(s): <b>Set himself on fire &amp; stepped off of step ladder &amp; a wire around his neck - suicide.</b>		<b>10 min</b>
(c) DUE TO: <b>Mental Depression</b>		<b>10 min</b>
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <b>None</b>		
19a. DATE OF OPERATION: <b>None</b>	19b. MAJOR FINDING OF OPERATION: <b>None</b>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <b>Home</b>	21c. (City or town) (County) (State) <b>Randallstown Balt. Md.</b>
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <b>Jan 3 '56 2:45 P.M.</b>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR? <b>Hung himself &amp; set himself on fire</b>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .		
SIGNATURE: <b>D.D. Caplio</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-3-56</b> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>
23. BURIAL, CREMATION, REMOVAL (Specify): <b>Burial</b>	DATE THEREOF: <b>1/6/1956</b>	NAME OF CEMETERY OR CREMATORY: <b>Mt. Olive Cemetery</b>
LOCATION (City, town, or county) (State): <b>Randallstown, Md.</b>	24. FUNERAL DIRECTOR: <b>Ellsworth Armacost</b> ADDRESS: <b>4600 Liberty Hgts. Ave. 7</b>	
DATE REC'D BY LOCAL REG. <b>1/4/56</b>	REGISTRAR'S SIGNATURE: <b>Ellsworth Armacost</b>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

368

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:			2. USUAL RESIDENCE (HOME) OF DECEASED:		
COUNTY	BALTIMORE		MARYLAND	STATE	MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town)	FORT HOWARD		LENGTH OF STAY (in this place)	5 HOURS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS	VETERANS ADMINISTRATION HOSPITAL		STREET ADDRESS	112 OSBORNE AVENUE	
3. NAME OF DECEASED:			4. DATE OF DEATH:		
(First)	(Middle)	(Last)	(Month)	(Day)	(Year)
CHARLES O. SCHOBURG			JANUARY 22 1956		
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR
MALE	WHITE	SINGLE	APRIL 23, 1914	41 yrs.	Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
Clerk		Cigar Counter		Baltimore, Maryland	
13. FATHER'S NAME:			14. MOTHER'S MAIDEN NAME:		
Herman Schoberg			Rose Gardner		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)			16. SOCIAL SECURITY No.		17. INFORMANT & ADDRESS:
Yes PTE			218-03-3128		Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.

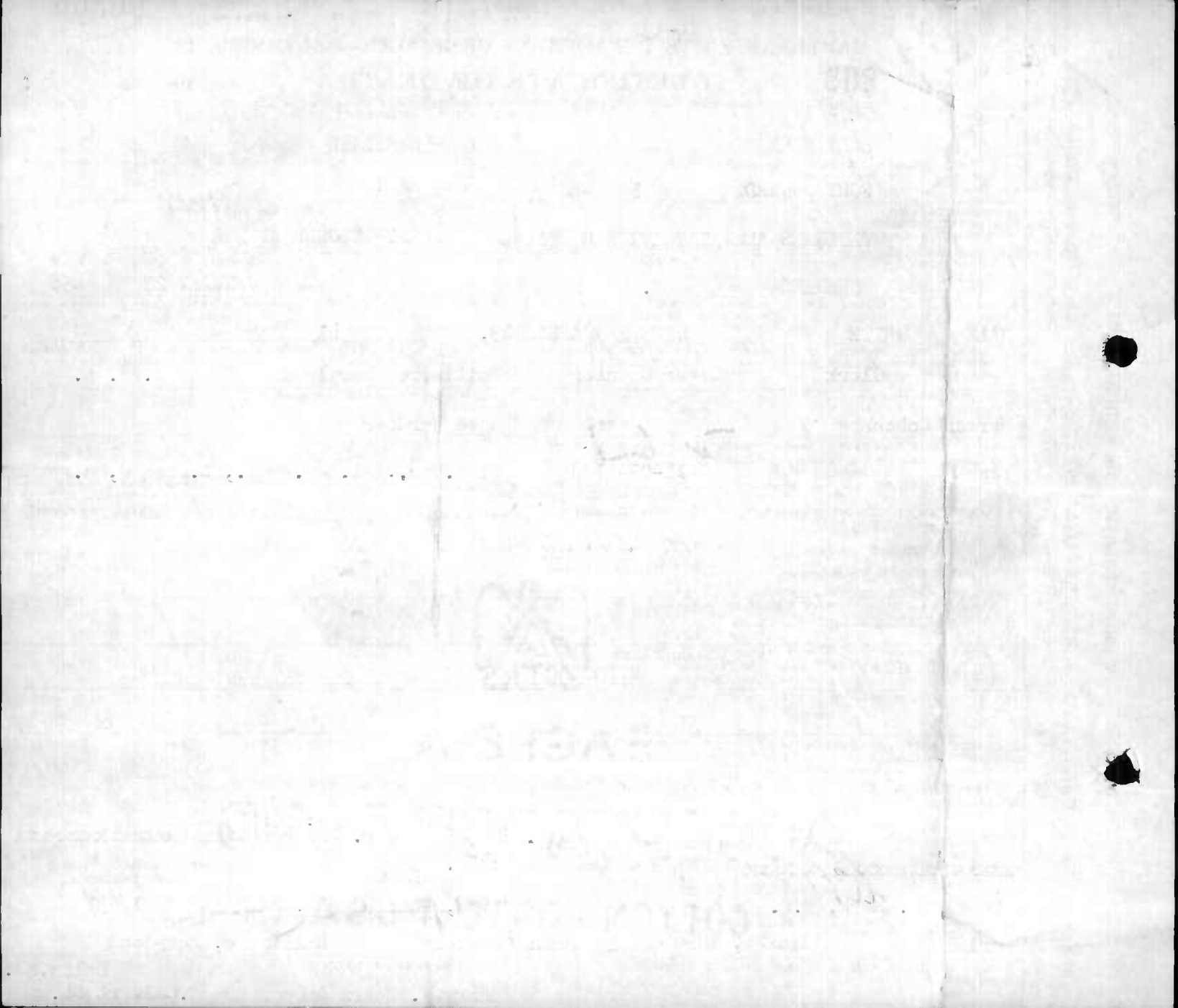
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
IMMEDIATE CAUSE		
(A) RHEUMATIC ENDOCARDITIS WITH MITRAL STENOSIS		UNKNOWN
ANTECEDENT CAUSE (S)		
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		
(B) DUE TO		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.		
ACUTE PULMONARY EDEMA		

19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While at work Not while at work		21F. HOW DID INJURY OCCUR?	
VA M.		4:45 PM 9:45 PM			
22. I hereby certify that I attended the deceased from Jan. 22, 1956, to Jan. 22, 1956, and that death occurred at 9:45 PM, from the causes and on the date stated above.					
SIGNATURE		ADDRESS		DATE SIGNED	
Donald D. Mark, M.D.		M. D. VAH, FORT HOWARD, MARYLAND		1/23/56	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
Burial		Jan 26, 1956		Holy Cross Cemetery	
LOCATION (City, town, or county) (State)		Baltimore, Maryland			
OATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
1/24/56		[Signature]		Henry W. Mears & Sons 805 N. Calvert St. Balto. Md.	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00361

369

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Perry Hall</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>E. Joppa Road</u>				STREET ADDRESS (If rural give location) <u>E. Joppa Road</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Fred Frederick Christian Schwartz</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Jan. 23, 1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Dec. 29, 1905</u>	9. AGE last birthday <u>50</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Florist</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Florist</u>		11. BIRTHPLACE (State or foreign country) <u>Balto. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Herman Schwartz</u>				14. MOTHER'S MAIDEN NAME <u>Caroline Dietz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-32-0978</u>		17. INFORMANT & ADDRESS <u>Mrs. Pauline M. Schwartz E. Joppa Rd.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
1420.1 IMMEDIATE CAUSE (A) <u>Coronary Artery Disease (Thrombosis)</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 week.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Sclerosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>Jan 30, 1956</u> , to <u>Jan 23, 1956</u> , that I last saw the deceased alive on <u>Jan 14, 1956</u> , and that death occurred at <u>10 a</u> M, from the causes and on the date stated above.							
SIGNATURE <u>J. J. Standing</u>		M. D. <u>3805 Belair Rd Baltimore, Md.</u>		DATE SIGNED <u>Jan 24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 26, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Michael's Lutheran</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>Jan. 27, 1956</u>		REGISTRAR'S SIGNATURE <u>Dr. Walter Hemmett</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Lorraine Funeral Home</u>		ADDRESS <u>7401 Belair Rd</u>	

RECEIVED

JAN 27 1956

BUREAU V. E.

100381

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 13

# CERTIFICATE OF DEATH

203

File Date

1. DEATH RECORD NUMBER

DEATH DATE

DEATH TIME

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DEATH CAUSE

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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

370

## CERTIFICATE OF DEATH

00362

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		STATE <u>Maryland</u> COUNTY <u>Balto</u>		CITY <u>Baltimore (Arbutus)</u>		TOWN <u>Baltimore (Arbutus)</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		TOWN	
TOWN <u>Fort Howard</u>		<u>37 Days</u>		TOWN <u>Baltimore (Arbutus)</u>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Veterans Administration Hospital</u>				STREET ADDRESS (If rural give location) <u>1106 Sulphur Spring Road</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>VERNON</u> <u>SCOTT</u>				<u>January 6</u> <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>Colored</u>	<u>Married</u>	<u>August 8, 1894</u>	<u>61</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Chauffeur</u>		<u>Paper Box Co.</u>		<u>Halethorpe, Maryland</u>		<u>U. S. A.</u>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Henry Scott</u>				<u>Hannah MN: Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>Yes</u>		<u>Unknown</u>		<u>Clin. Rec. Vet. Adm. Hosp. Ft. Howard, Md.</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
196X IMMEDIATE CAUSE (A) <u>CARCINOMA OF THE LEFT ORBIT WITH METASTASIS</u>						<u>1 YEAR</u>	
ANTECEDENT CAUSE(S) <u>TO LUNGS AND LIVER</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov. 30</u> , 19 <u>55</u> , to <u>Jan. 6</u> , 19 <u>56</u> , and that death occurred at <u>1:25 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Donald D. Mark, M.D.</u>				ADDRESS (Street, city, town, or county) <u>VAH, FORT HOWARD, MARYLAND</u> DATE SIGNED <u>1-6-56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>Jan. 9, 1956</u>		<u>Western Star. Cem.</u>		<u>Catonsville Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<u>JAN 9 1956</u>		<u>Lawson L. Fisher</u>		<u>Mrs. Katie R. Williams</u>		<u>322 N. Schroeder St. Baltimore</u>	
DATE						<u>Mrs. Katie R. Williams 322 N. Schroeder St.</u>	

# CERTIFICATE OF DEATH

FILE NO.

DECEASED'S NAME (PRINTED)

DATE OF DEATH

AGE

PLACE OF BIRTH

CAUSE OF DEATH

SEX

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

DATE OF DEATH

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TIME OF DEATH

BUREAU V. S.

JAN 9 1956

RECEIVED



371  
CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Catonsville 24</u>		LENGTH OF STAY (in this place) <u>See Rec 16 1453</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore 23</u> <u>3Y01-4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Spring Grove Hospital</u>				STREET ADDRESS (If rural give location) <u>2318, Frederick Ave</u> ✓			
3. NAME OF DECEASED:				4. DATE (Month) (Day) (Year) OF DEATH			
(First) <u>CAROLINE</u>		(Middle) <u>K</u>		(Last) <u>SEIPPEL</u>		<u>10-21</u> 19 <u>56</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <u>W</u>	8. DATE OF BIRTH: <u>10.17.1859</u>	9. AGE last birthday <u>96</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>		11. BIRTHPLACE (State or foreign country): <u>Baltimore Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME: <u>Henry Ott</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT & ADDRESS: <u>Henry W. Seippel-2318 Fredk-Ave</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) <u>Bilateral pleural effusions</u>							
ANTECEDENT CAUSE (B) <u>Decompensatory heart disease</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>Arteriosclerotic cardiovascular disease</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12.16</u> , 19 <u>53</u> , to <u>1.21</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1.21</u> , 19 <u>56</u> , and that death occurred at <u>1.30</u> P M, from the causes and on the date stated above.							
SIGNATURE <u>Rena Becker</u>		ADDRESS <u>M. D. Spring Grove Hospital</u>		DATE SIGNED <u>1/21/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 24/56</u>		NAME OF CEMETERY OR CREMATORY <u>Louisa Park Baltimore Md</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>1/24/56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harry</u>		FUNERAL DIRECTOR <u>A.B. Whippert</u>		ADDRESS <u>1300 Eutaw Pl.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 26 1956

RECEIVED

1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00364

372

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTIMORE</u>		STATE <u>Md.</u>		COUNTY <u>BALTIMORE</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>CATONSVILLE</u>		<u>8 yrs.</u>		TOWN <u>CATONSVILLE</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>504 FOREST LANE</u>				STREET ADDRESS (If rural give location) <u>504 FOREST LANE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Anne</u> (Middle) <u>ELAINE</u> (Last) <u>SMITH</u>				(Month) <u>JAN.</u> (Day) <u>24</u> (Year) <u>1956</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>MAY 22, 1924</u>	9. AGE last birthday <u>31</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>DOMESTIC</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>EDGAR HILDITCH</u>				14. MOTHER'S MAIDEN NAME <u>MARY L. LYNN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-12-7876</u>		17. INFORMANT & ADDRESS <u>EARL SMITH 504 FOREST LANE.</u>			
<b>18. MEDICAL CERTIFICATION</b>						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						<u>13 months</u>	
2041 IMMEDIATE CAUSE (A) <u>Leukemia Myeloid</u>							
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>11/4</u> , 19 <u>46</u> , to <u>1/24</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/23</u> , 19 <u>56</u> , and that death occurred at <u>4:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Eliot W. Johnson M.D.</u>				ADDRESS (Street, city, town, state) <u>3432 Indian Ave. Balt. Md 28 Me 1/24/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-27-56</u>		NAME OF CEMETERY OR CREMATORY <u>WESTERN</u>		LOCATION (City, town, or county) <u>BALTIMORE Md.</u>	
24. REG'D BY REGISTRAR <u>Jan. 26, 1956</u>		REGISTRAR'S SIGNATURE <u>V. E. Harris</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>George L. Schaub</u>		ADDRESS <u>2101 Frederick Ave.</u>	

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

## CERTIFICATE OF DEATH

Form No. 10

DEATH AND BURIAL RECORDS - 1936

DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

AGE AT DEATH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

DATE OF DEPARTURE

PLACE OF DEPARTURE

DATE OF RETURN

PLACE OF RETURN

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BUREAU V. S.

JAN 26 1936

RECEIVED

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

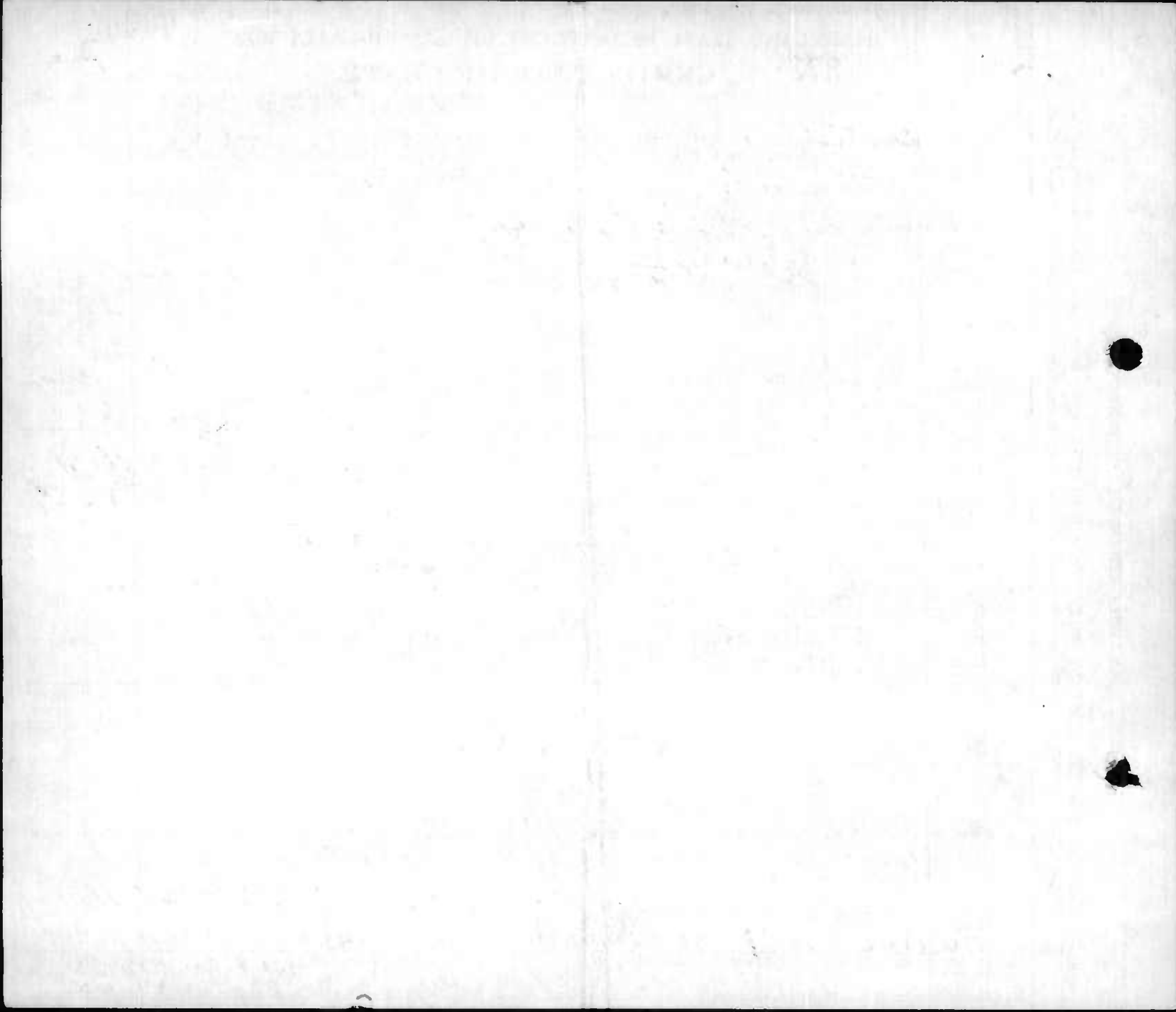
00365

373

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>52 Catonsville</u>		LENGTH OF STAY in this place <u>2 yrs. 18 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u> <u>3101.4</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hosp.</u>				STREET ADDRESS (If rural give location) <u>420 W. Franklin St.</u>			
3. NAME OF DECEASED: (Type or Print) <u>Ella (ELLEN) Starr Smith</u>				4. DATE (Month) (Day) (Year) OF DEATH: <u>1-3-1956</u>			
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>6/8/1879</u>	9. AGE last birthday <u>76</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Unknown</u>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY: <u>Ireland</u>	
13. FATHER'S NAME: <u>Peter Starr</u>				14. MOTHER'S MAIDEN NAME: <u>Mary McQuade</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY NO. <u>Unk.</u>		17. INFORMANT'S ADDRESS: <u>Brook Spring Grove State Hosp.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Myocardial Infarction</u>							
ANTECEDENT CAUSE (S) DUE TO (B) <u>Atherosclerotic Coronary thrombosis</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE, STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>7-</u> , 19 <u>53</u> to <u>1-3-</u> , 19 <u>56</u> that I last saw the deceased alive on <u>1-3-</u> , 19 <u>56</u> , and that death occurred at <u>10:40</u> AM, from the causes and on the date stated above.							
SIGNATURE <u>Spella Wachler</u>				DATE SIGNED <u>1/3/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>				DATE THEREOF <u>1-7-56</u>			
NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL CEM.</u>				LOCATION (City, town, or county) (State) <u>4300 OLD FREDERICK RD BALTO, MD</u>			
DATE REC'D BY LOCAL REGISTRAR <u>6-56</u>		REGISTRAR'S SIGNATURE <u>Howe Holman</u>		24. FUNERAL DIRECTOR <u>Charles S. Guler</u> ADDRESS <u>901 S. CONKLING ST. BALTO., MD.</u>			





## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filled with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## 374

# CERTIFICATE OF DEATH

00366

44

Reg. Dist. No. ....

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>BALTIMORE</b>	<b>MARYLAND</b>	STATE <b>MARYLAND</b>	COUNTY <b>Howard</b>
CITY (If outside corporate limits, write RURAL or and give nearest town) <b>FORT HOWARD</b>	LENGTH OF STAY (in this place) <b>70 Days</b>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>ELKRIDGE</b>	<b>136-2</b>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>		STREET ADDRESS (If rural give location) <b>1711 Levering Avenue</b>	
3. NAME OF DECEASED (First) (Middle) (Last) <b>JOSEPH SMITH</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>January 6, 1956</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>MARRIED</b>	8. DATE OF BIRTH <b>June 24, 1893</b>
9. AGE last birthday <b>62</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Car Company</b>	11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Jim Smith</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <b>WW YES WW-1</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>	
17. INFORMANT & ADDRESS <b>Clin. Rec., Vet. Adm. Hosp. Fort Howard, Md.</b>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>2040 IMMEDIATE CAUSE (A) LYMPHATIC LEUKEMIA</b>		INTERVAL BETWEEN ONSET AND DEATH <b>16 Mos.</b>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) DUE TO (C)			
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION <b>12-2-55</b>		19b. MAJOR FINDINGS OF OPERATION <b>CLOSED THORACOTOMY, DRAINAGE</b>	
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work et work	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>10-28-55</b> , to <b>1-6-56</b> , and that death occurred at <b>3:50 PM</b> , from the causes and on the date stated above.			
SIGNATURE <b>DONALD D. MARK</b>		ADDRESS (Street, city, town, state) <b>M.D. VAH Ft. Howard, Md</b>	
DATE SIGNED <b>1/7/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>JAN 11, 1956</b>	
NAME OF CEMETERY OR CREMATORY <b>Baltimore National Cemetery Baltimore, Maryland</b>		LOCATION (City, town, or county) (State)	
24. REC'D BY REGISTRAR <b>JAN 9 1956</b>		REGISTRAR'S SIGNATURE <b>Darson L. Farber</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. Cook-Blight Inc. Funeral Home</b>		ADDRESS <b>6009 Harford Road, Baltimore, Md.</b>	

1930

NEW YORK STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

# CERTIFICATE OF DEATH

REG. DIST. NO.

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

TO LIVE

TO LIVE

DATE OF DEATH

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INSTRUCTIONS  
TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.  
VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Reg. Dist. No. 30

Item 11, Film G191 1-24-56 et

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Baltimore		MARYLAND		STATE Md.		COUNTY Baltimore	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN Catonsville Gardens		6 Mos.		TOWN Catonsville Gardens		52	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 1528 Ingleside Ave				STREET ADDRESS (If rural give location) 1528 Ingleside Ave.,			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
Joseph Snapp				Jan. 17, 19 56.			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
Male	White	Widower	Feb. 26, 1865	90 yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
Laborer					Va.		
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Unknown				Rebecca Clauser			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
no		none		Mrs. H. H. Blackburn 1528 Ingleside A.			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
334X IMMEDIATE CAUSE (A)				Carcinoma of the esophagus.			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				INTERVAL BETWEEN ONSET AND DEATH			
				2 yrs.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan. 10, 19 56, to Jan. 17, 19 56, that I last saw the deceased alive on Jan. 15, 19 56, and that death occurred at 2:45 P.M. from the causes and on the date stated above.							
SIGNATURE				ADDRESS (Street, city, town, state)		DATE SIGNED	
J. C. McLean McKay				6014 Edman Ave		Jan 17, 1956	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		1-19-1956		Good Shepherd		Howard Co., Md.	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE Jan. 17, 1956		J. E. Harris		G. Howard Strong 3207 W. North Ave.,			

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MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# CERTIFICATE OF DEATH

Reg. Dist. No.

1. DECEASED PERSON'S NAME OR DECEASED

DATE OF DEATH

PLACE OF DEATH

2. DECEASED PERSON'S RESIDENCE

3. DECEASED PERSON'S OCCUPATION

4. DECEASED PERSON'S AGE

5. DECEASED PERSON'S SEX

6. DECEASED PERSON'S RACE

7. DECEASED PERSON'S MARITAL STATUS

8. DECEASED PERSON'S RELIGION

9. DECEASED PERSON'S EDUCATION

10. DECEASED PERSON'S BIRTH DATE

11. DECEASED PERSON'S BIRTH PLACE

12. DECEASED PERSON'S BIRTH TIME

13. DECEASED PERSON'S BIRTH WEIGHT

14. DECEASED PERSON'S BIRTH LENGTH

15. DECEASED PERSON'S BIRTH HEIGHT

16. DECEASED PERSON'S BIRTH HEAD CIRCUMFERENCE

17. DECEASED PERSON'S BIRTH ARM CIRCUMFERENCE

18. DECEASED PERSON'S BIRTH LEG CIRCUMFERENCE

19. DECEASED PERSON'S BIRTH SKIN COLOR

20. DECEASED PERSON'S BIRTH HAIR COLOR

21. DECEASED PERSON'S BIRTH EYE COLOR

22. DECEASED PERSON'S BIRTH NOSE COLOR

23. DECEASED PERSON'S BIRTH MOUTH COLOR

24. DECEASED PERSON'S BIRTH TONGUE COLOR

25. DECEASED PERSON'S BIRTH TEETH COLOR

26. DECEASED PERSON'S BIRTH FINGERS COLOR

27. DECEASED PERSON'S BIRTH TOES COLOR

28. DECEASED PERSON'S BIRTH NAILS COLOR

29. DECEASED PERSON'S BIRTH SKIN CONDITION

30. DECEASED PERSON'S BIRTH HAIR CONDITION

31. DECEASED PERSON'S BIRTH EYE CONDITION

32. DECEASED PERSON'S BIRTH MOUTH CONDITION

33. DECEASED PERSON'S BIRTH TONGUE CONDITION

34. DECEASED PERSON'S BIRTH TEETH CONDITION

35. DECEASED PERSON'S BIRTH FINGERS CONDITION

36. DECEASED PERSON'S BIRTH TOES CONDITION

37. DECEASED PERSON'S BIRTH NAILS CONDITION

38. DECEASED PERSON'S BIRTH SKIN TONE

39. DECEASED PERSON'S BIRTH HAIR TONE

40. DECEASED PERSON'S BIRTH EYE TONE

41. DECEASED PERSON'S BIRTH MOUTH TONE

42. DECEASED PERSON'S BIRTH TONGUE TONE

43. DECEASED PERSON'S BIRTH TEETH TONE

44. DECEASED PERSON'S BIRTH FINGERS TONE

45. DECEASED PERSON'S BIRTH TOES TONE

46. DECEASED PERSON'S BIRTH NAILS TONE

47. DECEASED PERSON'S BIRTH SKIN TONE

48. DECEASED PERSON'S BIRTH HAIR TONE

49. DECEASED PERSON'S BIRTH EYE TONE

50. DECEASED PERSON'S BIRTH MOUTH TONE

51. DECEASED PERSON'S BIRTH TONGUE TONE

52. DECEASED PERSON'S BIRTH TEETH TONE

53. DECEASED PERSON'S BIRTH FINGERS TONE

54. DECEASED PERSON'S BIRTH TOES TONE

55. DECEASED PERSON'S BIRTH NAILS TONE

56. DECEASED PERSON'S BIRTH SKIN TONE

57. DECEASED PERSON'S BIRTH HAIR TONE

BUREAU V. S.

JAN 18 1930

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BUREAU V. S.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00368

376

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Md</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Cockeysville</i>		<i>10 yrs.</i>		TOWN <i>Baltimore</i>		<i>3Y01-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS		(If rural give location)	
<i>90 Masonic Home</i>				<i>3621 Redwood Ave</i>		<i>✓</i>	
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Martha Ellen Snider</i>				<i>Jan. 27 1956</i>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b> (Months) (Days) <b>IF UNDER 24 HRS.</b> (Hours) (Min.)	
<i>Female</i>	<i>white</i>	<i>Widowed</i>	<i>Dec 11th, 1867</i>		<i>88</i>	<i>88 yrs.</i>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>Housewife</i>		<i>at home</i>		<i>Maryland</i>		<i>U.S.</i>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>William H. Welmon</i>				<i>Sarah J. Ayers</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
		<i>-</i>		<i>Elaine Dennis, Masonic Home</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>422.1 IMMEDIATE CAUSE</b> (A) <i>arteriosclerotic cardiovascular disease</i>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
ANTECEDENT CAUSE(S) DUE TO						<i>Oct 17, 1952</i>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST, DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify</b> that I attended the deceased from <i>Oct 17, 1952</i> , to <i>Jan 27, 1956</i> , that I last saw the deceased alive on <i>January 27, 1956</i> , and that death occurred at <i>8:35 P.M.</i> from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Walter T. Kees</i>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
				<i>Cockeysville, Md</i>		<i>Jan 27-56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b> (State)	
<i>Burial</i>		<i>1/31/56</i>		<i>Lorraine Cemetery</i>		<i>Hoodlawn, Md</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>Anna MacRae</i>		<i>Wm. Cook Inc.</i>		<i>1217 H. Paul St</i>			



# CERTIFICATE OF DEATH

578

NAME OF DECEASED [Faint text, possibly "JOHN J. SMITH"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "New York City"]		OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]	
DATE OF DEATH [Faint text, possibly "Jan 30 1956"]		TIME OF DEATH [Faint text, possibly "10:00 AM"]		PLACE OF DEATH [Faint text, possibly "Home"]	
NAME OF PHYSICIAN [Faint text, possibly "Dr. J. H. Smith"]		NAME OF FUNERAL HOME [Faint text, possibly "Smith & Son"]		NAME OF BURIAL PLACE [Faint text, possibly "Oakwood Cemetery"]	
NAME OF NEXT OF KIN [Faint text, possibly "Mrs. J. H. Smith"]		ADDRESS OF NEXT OF KIN [Faint text, possibly "123 Main St, Birmingham, Ala."]		SIGNATURE OF NEXT OF KIN [Faint text, possibly "Mrs. J. H. Smith"]	
NAME OF REGISTRAR [Faint text, possibly "John J. Smith"]		ADDRESS OF REGISTRAR [Faint text, possibly "123 Main St, Birmingham, Ala."]		SIGNATURE OF REGISTRAR [Faint text, possibly "John J. Smith"]	

**RECEIVED**  
 JAN 30 1956  
 BUREAU V. S.

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE USED FOR ANY OTHER PURPOSE.  
 IT IS THE DUTY OF THE REGISTRAR TO SEE THAT THIS CERTIFICATE IS CORRECTLY FILLED OUT AND THAT THE DEATH IS PROPERLY REGISTERED.  
 THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE IF IT IS NOT CORRECTLY FILLED OUT.  
 THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE IF IT IS NOT CORRECTLY FILLED OUT.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

210  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

00369  
Reg. Dist. *22*

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <i>Balto</i>		MARYLAND		STATE <i>md</i>		COUNTY <i>Balto</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
<i>51</i> <i>Town</i> <i>Lansdowne</i>		<i>30 yr</i>		<i>Lansdowne</i>		<i>51</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>22 - 5th ave</i>				STREET ADDRESS (If rural, give location) <i>22 5th ave</i>			
<b>3. NAME OF DECEASED:</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>Annie E. Snodgrass</i>				<i>Jan 17 1956</i>			
<b>5. SEX:</b>		<b>6. COLOR OR RACE:</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH:</b>	
<i>7</i>		<i>W</i>		<i>Widow</i>		<i>Jan 2 1894</i>	
<b>9. AGE last birthday:</b>		<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of work life, even if retired):		<b>11. BIRTHPLACE</b> (State or foreign country):		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>72 yrs.</i>		<i>at home house wife</i>		<i>Balto. Co Md.</i>		<i>usa.</i>	
<b>13. FATHER'S NAME:</b> <i>James</i>				<b>14. MOTHER'S MAIDEN NAME:</b> <i>Annie O'Brien</i>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)				<b>16. SOCIAL SECURITY No.:</b> <i>216-03-2716</i>		<b>17. INFORMANT &amp; ADDRESS:</b> <i>Edw A Short Jr 22 5th ave</i>	

<b>18. MEDICAL CERTIFICATION</b>				<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:</b>					
Immediate cause (a) <i>174X</i>		DUE TO <i>Acute Cardiac failure</i>			
Antecedent cause(s) (b)		DUE TO <i>Carcinoma Intestine</i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)					
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <i>Operation Hypertrophy 1944</i>					
<b>19a. DATE OF OPERATION:</b>		<b>19b. MAJOR FINDING OF OPERATION:</b>			
<b>20. AUTOPSY?</b> Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>					
<b>21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/></b>		<b>21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY</b>		<b>21c. (City or town) (County) (State)</b>	
<b>21d. TIME (Month) (Day) (Year) (Hour) OF INJURY</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>	
<b>22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>					
<b>SIGNATURE</b> <i>Dr. M. Kieffer</i>		<b>1010 Leaden</b>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <i>Jan 17 56</i>	
				<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAM.</b> <input type="checkbox"/>	
<b>23. BURIAL, CREMATION, REMOVAL (Specify):</b> <i>Burial</i>		<b>DATE THEREOF</b> <i>2/20/56</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>New Cathedral Cem.</i>	
				<b>LOCATION (City, town, or county) (State)</b> <i>4300 Old Frederick Rd. Balt.</i>	
<b>DATE REC'D BY LOCAL REG.</b> <i>1-18-56</i>		<b>REGISTRAR'S SIGNATURE</b> <i>John J. Cowan + Son</i>		<b>24. FUNERAL DIRECTOR</b> <i>John J. Cowan + Son</i>	
				<b>ADDRESS</b> <i>9 Collins St.</i>	

RECEIVED  
JAN 10 1900  
U.S. DEPT. OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D.C.

STATE OF NEW YORK  
COUNTY OF ...  
IN SENATE  
JANUARY 10, 1900  
REPORT OF THE  
COMMISSIONERS OF THE  
LAND OFFICE  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE  
JANUARY 10, 1899  
ALBANY: J.B. LIPPINCOTT & CO., PRINTERS.  
1900

377

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Randallstown

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Winans Road

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MarylandCOUNTY BaltimoreCITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Randallstown

STREET ADDRESS (If rural give location)

Winans Road

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

HarryJames Snyder

4. DATE

(Month)

(Day)

(Year)

OF DEATH: Jan3019 56

## 5. SEX:

6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

MaleWhite11/23/188372

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland12. CITIZEN OF WHAT COUNTRY? U.S.A.

## 13. FATHER'S NAME:

John George Snyder

## 14. MOTHER'S MAIDEN NAME:

Wilamenia Florence Newman

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

NoNo

16. SOCIAL SECURITY No.:

220-05-9860A

17. INFORMANT &amp; ADDRESS:

Mrs Ella May Snyder

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

One Year.

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY ?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED White at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from Jan 30, 1956, to Jan 30, 1956, that I last saw the deceasedalive on 1/30, 1956, and that death occurred at 7:30 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION, REMOVAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORIUM

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Jan 10, 1956Harold A. Newell2204 Gibbitts Rd, Balt, Md. 1/30/56Randallstown, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

FEB 7 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00371

202

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>BALTO.</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>BALTO</u>	
CITY OR TOWN <u>DUNDALK (22)</u>		LENGTH OF STAY (in this place) <u>15 YRS</u>		CITY OR TOWN <u>DUNDALK (22)</u>		CITY OR TOWN <u>53</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GLENHURST RD</u>				STREET ADDRESS (If rural give location) <u>GLENHURST RD</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
(First) (Middle) (Last) <u>MILDRED LUTHARDT SNYDER</u>				<u>1-29</u> <u>1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>3 JUNE 1899</u>	9. AGE last birthday <u>56</u> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>COOK</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INDUSTRIAL FOOD</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHARLES LUTMARDT</u>				14. MOTHER'S MAIDEN NAME <u>ELIZABETH HILL</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-09 8037</u>		17. INFORMANT & ADDRESS <u>JAMES G. SNYDER - SAME</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
156.1 IMMEDIATE CAUSE (A) <u>CH of liver</u>				INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify</b> that I attended the deceased from <u>Nov 20 1955</u> to <u>Jan 12 1956</u> , that I last saw the deceased alive on <u>Nov 20 1955</u> , and that death occurred at <u>1-29-56</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Jack Chellus</u>				ADDRESS (Street, city, town, state) <u>BALTO 22 21 Hurst Ln</u>		DATE SIGNED <u>1-31-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>2-2-56</u>		NAME OF CEMETERY OR CREMATORY <u>LENDON PARK</u>		LOCATION (City, town, or county) (State) <u>BALTO. MD.</u>	
24. REC'D BY REGISTRAR <u>Feb. 2, 1956</u>		REGISTRAR'S SIGNATURE <u>Dawson L. Farkley</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Walter Duke Dudley Runkel, MD</u>		ADDRESS	

15731

MADE IN THE STATE OF NEW YORK

# CERTIFICATE OF DEATH

2 2

Age, Sex, Race

Place of Birth, Date of Birth

Married

Occupation

Education

Religion

Usual Residence

Place of Death

Time of Death

Cause of Death

Immediate Cause

Underlying Cause

Manner of Death

Signature of Physician

Signature of Coroner

Signature of Registrar

Signature of Witness

Signature of Family

Signature of Minister

Signature of Priest

Signature of Rabbi

Signature of Imam

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

Signature of Other

BUREAU V. S.

FEB 2 1956

RECEIVED



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

00372

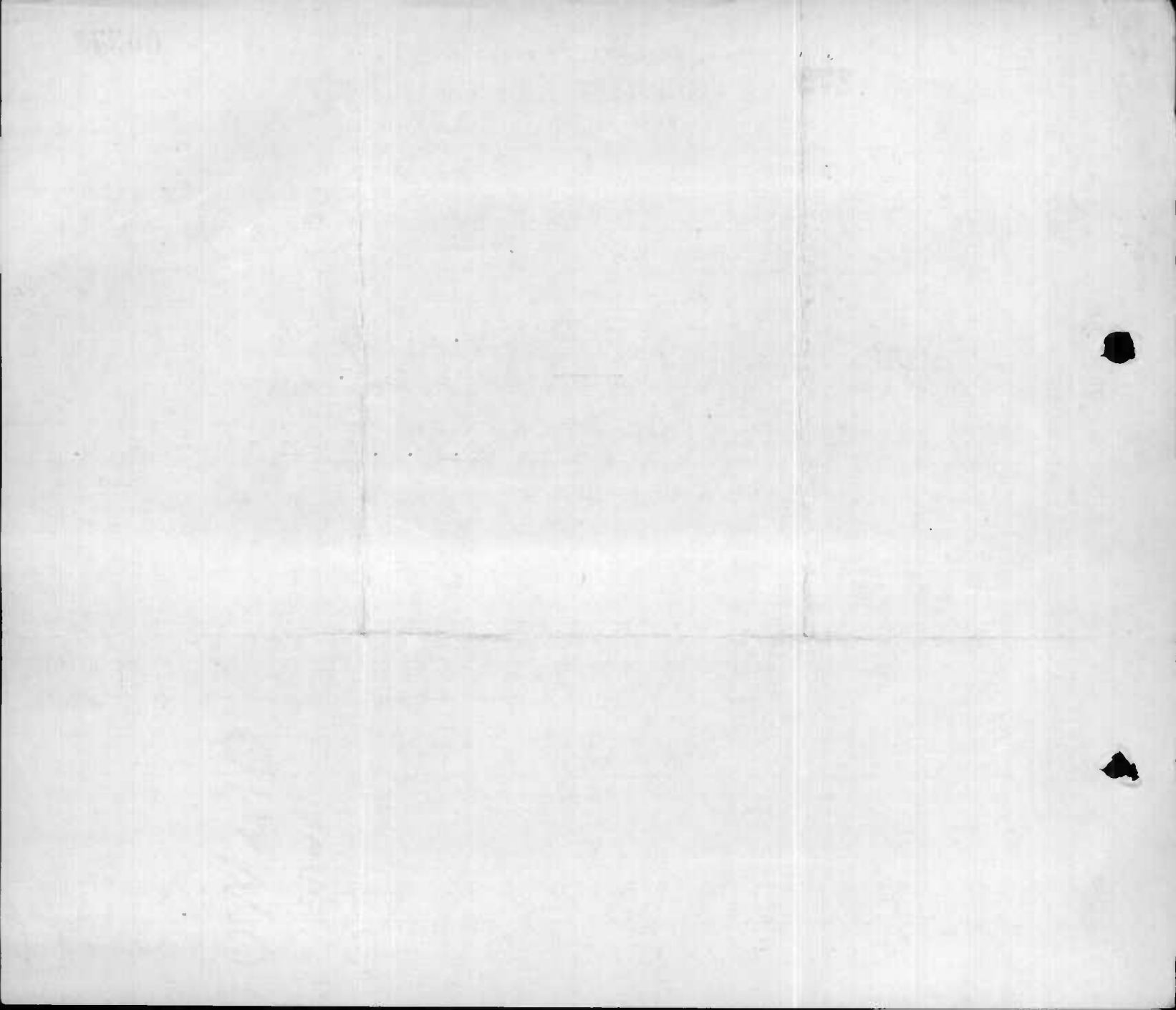
378

# CERTIFICATE OF DEATH

## FOR MEDICAL EXAMINERS

Reg. Dist. No. 38

1. PLACE OF DEATH- COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Maryland</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Riderwood</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sorenson Nursing Home</u>		STREET ADDRESS (If rural, give location) <u>3734 Beech Avenue</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>Nellie</u>	(Middle) <u>Kelly Stack</u>	(Last) <u>Snyder</u>
4. DATE OF DEATH	(Month) <u>January</u>	(Day) <u>29</u>	(Year) <u>1956</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Nov. 28, 1890</u>
9. AGE last birthday <u>65</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Joseph D. Stack</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Neville</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. Wm. H. Carroll</u>		<u>Lutherville, Md.</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
(a) Immediate cause <u>331x Cerebrovascular Accident</u>			<u>1 month</u>
(b) Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>Cerebral arteriosclerosis</u>			
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing in the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at work <input type="checkbox"/> Nnt while at work <input type="checkbox"/>	
		HOW DID INJURY OCCUR?	
22. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes <input checked="" type="checkbox"/> , accident <input type="checkbox"/> , suicide <input type="checkbox"/> , homicide <input type="checkbox"/> , undetermined <input type="checkbox"/> .			
SIGNATURE <u>J. M. Morgan</u>		DATE SIGNED <u>1/31/56</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>	
DATE REC'D BY LOCAL REG. <u>3-1-56</u>		ADDRESS <u>15 E. Biddle St. Baltimore Md.</u>	
REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>W. W. Meeks</u>	
		ADDRESS <u>Box 805 N. Calvert St.</u>	



## MARYLAND STATE DEPARTMENT OF HEALTH

00373

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 9, Film 101-1-26-56 et

1. PLACE OF DEATH COUNTY <u>Balto.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Balto.</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1889 Augusta Ave</u>		STREET ADDRESS (If rural, give location) <u>1889 Augusta Ave.</u>	
3. NAME OF DECEASED (Type or Print) <u>Marcyanna</u>	(First) (Middle) (Last) <u>Sobus</u>	4. DATE OF DEATH (Month) (Day) (Year) <u>1</u> <u>16</u> <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Oct. 16, 1869</u>
9. AGE last birthday <u>86</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>Poland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nathan Poremski</u>		14. MOTHER'S MAIDEN NAME <u>Anna</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>1</u>	
17. INFORMANT AND ADDRESS <u>Frances Sobus 1889 Augusta Ave.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) myocarditis, acuteAntecedent cause(s) (b) atherosclerosisDiseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) myocarditis, chronic

INTERVAL BETWEEN ONSET AND DEATH

1 week15 years10 years

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Jan, 1945, to Jan 16, 1956, that I last saw the deceasedalive on Jan 15, 1956, and that death occurred at 1:15 P. m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

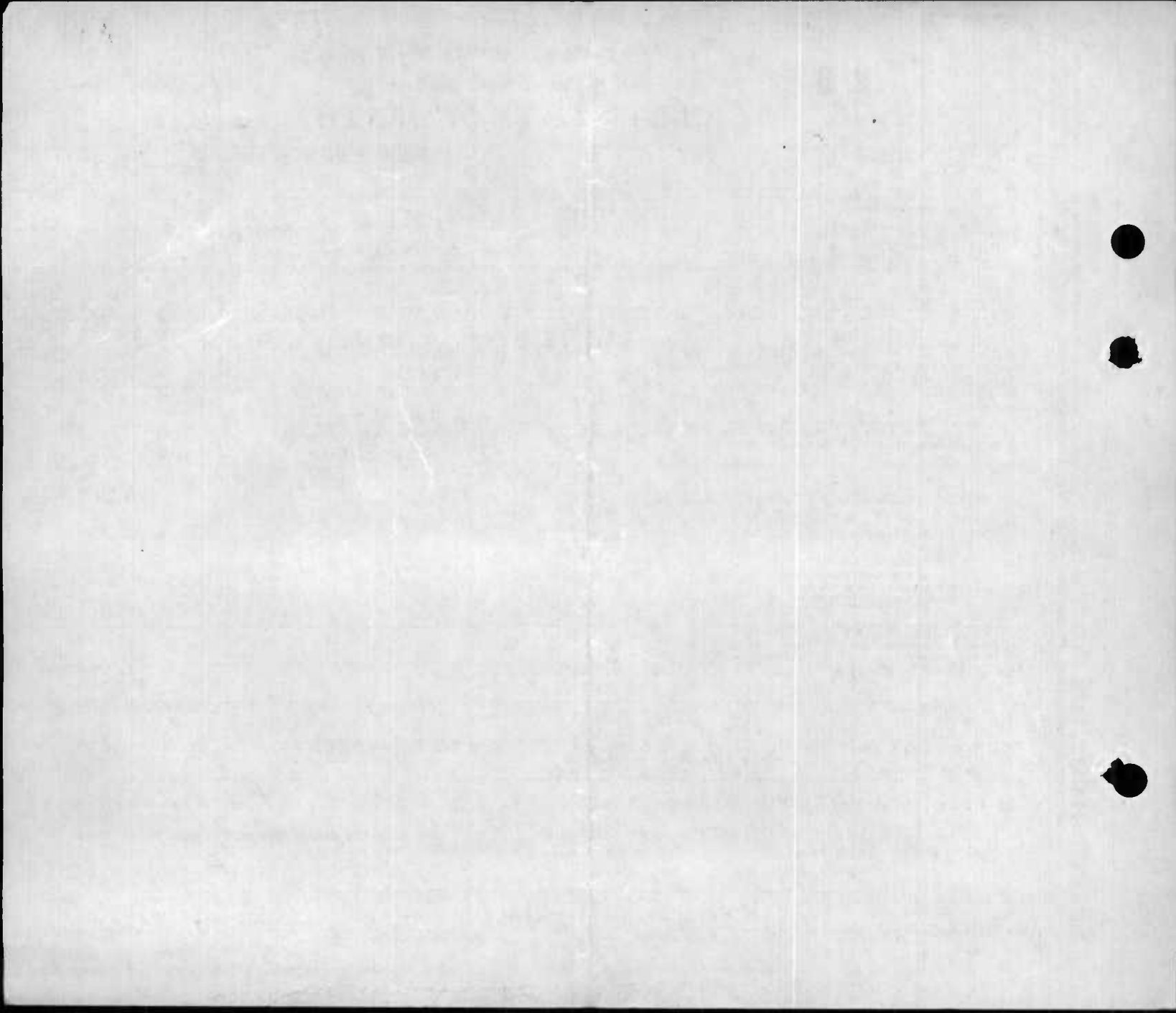
DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>1-19-1956</u>	<u>Sacred Heart of Mary</u>	<u>Baltimore</u>	<u>Maryland</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1/17/56</u>	<u>G. W. Hedrick</u>	<u>Walter S. Szymanski</u>	<u>10014 Dundalk Rd. Balt. m.d.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Balto</u> MARYLAND		STATE <u>Md.</u> COUNTY <u>Balto</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Parkville</u>	
CITY OR TOWN <u>Parkville</u>		LENGTH OF STAY (in this place) <u>2 yrs.</u>		STREET ADDRESS (If rural give location) <u>7823 Clarkworth Pl.</u>		STREET ADDRESS <u>7823 Clarkworth Pl.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7823 Clarkworth Pl.</u>				HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>7823 Clarkworth Pl.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>Anna Stassick</u>				<u>Jan 18 1956</u>			
5. SEX: <u>F.</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>		8. DATE OF BIRTH: <u>1885</u>	
9. AGE last birthday <u>70</u> yrs.		10. MONTHS <u>70</u>		11. DAYS <u>70</u>		12. HOURS <u>70</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>House work</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>At Home</u>		11. BIRTHPLACE (State or foreign country): <u>Russia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME: <u>Radje wonchick</u>			
14. MOTHER'S MAIDEN NAME: <u>Anna</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT & ADDRESS: <u>Vivian T. Little 7823 Clarkworth Pl.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Coronary thrombosis</u>						<u>1 day</u>	
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from <u>1/10</u> , 1956, to <u>1/17</u> , 1956, that I last saw the deceased alive on <u>1/16</u> , 1956, and that death occurred at <u>1:30</u> A.M., from the causes and on the date stated above.							
SIGNATURE <u>Harold E. Groat</u>				ADDRESS <u>8100 Harford Rd</u>		DATE SIGNED <u>1/18/56</u>	
23. BURIAL, CREMATION, REMOVAL, (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>JAN 20 1956</u>		NAME OF CEMETERY OR CREMATORY <u>FOREST HILL CEM.</u>		LOCATION (City, town, or county) <u>CLINTON N.Y.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1/19-56</u>		REGISTRAR'S SIGNATURE <u>J.W. Hedrick</u>		24. FUNERAL DIRECTOR <u>Doppel Bros.</u>		ADDRESS <u>7110 Belair Rd</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr G. L. F. 100 Hartford



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00375

380

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>Baltimore</b>		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>Towson</b>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Towson</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>1013 Regester Avenue</b>				STREET ADDRESS (If rural give location) <b>1013 Regester Avenue</b>			
<b>3. NAME OF DECEASED</b> (Type or Print) <b>Mrs. Bertha Frances Stevens</b>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <b>January 30th 19 56</b>			
<b>5. SEX</b> <b>female</b>		<b>6. COLOR OR RACE</b> <b>white</b>		<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <b>widowed</b>		<b>8. DATE OF BIRTH</b> <b>Oct. 28, 1874</b>	
				<b>9. AGE last birthday</b> <b>81</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days	
						<b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>at home</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Champlain, New York</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Joseph Barker</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Elizabeth Baker</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <b>Mr. Wynne A. Stevens, 1013 Regester Ave.</b>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>450.0</b> IMMEDIATE CAUSE (A) <b>Cerebral arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>			
ANTECEDENT CAUSE(S) DUE TO <b>Generalized arteriosclerosis</b>				<b>unknown</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>2D. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <b>at work</b> <input type="checkbox"/> <b>Not while at work</b> <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from Jan 27, 19 56, to Jan 30, 19 56, that I last saw the deceased alive on Jan 27, 19 56, and that death occurred at 7:00 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Fredrick J. Vollmer</i> M.D.				<b>DATE SIGNED</b> <i>6100 York Rd Baltimore Md 1-31-56</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <b>Cremation</b>		<b>DATE THEREOF</b> <b>Feb. 2, 1956</b>		<b>NAME OF CEMETERY OR CREMATORY</b> <b>Green Mount Cemetery</b>		<b>LOCATION (City, town, or county) (State)</b> <b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b> <i>FL 11956</i>		<b>REGISTRAR'S SIGNATURE</b> <i>Mark Gray</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Leonard J. Ruck, 5305 Harford Road #14</b>			

2401700000000000

1  
The following information was received from the Bureau of Health Statistics, Maryland, on February 2, 1956:

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

Reg. Dist. No.

1. NAME OF DECEASED

2. PLACE OF DEATH

3. SEX

4. RACE

5. DATE OF BIRTH

6. AGE

7. OCCUPATION

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. DATE OF DEATH

13. TIME OF DEATH

14. PLACE OF BIRTH

15. PLACE OF DEATH

16. PLACE OF DEATH

17. PLACE OF DEATH

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

381

## CERTIFICATE OF DEATH

00376

Reg. Dist. No. 37

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>MARYLAND</i>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <i>Cockeysville</i>				TOWN <i>BALTIMORE</i>		<i>3V01-4</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Masonic Home</i>				STREET ADDRESS (If rural give location) <i>1602 FREDERICK ROAD</i>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>IDA M. Stoddard</i>				<i>Jan 20 1956</i>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<i>Female</i>	<i>White</i>	<i>Married</i>	<i>MARCH 1, 1872</i>	<i>83</i> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<i>HOUSEWIFE</i>			<i>At Home</i>		<i>Baltimore Md.</i>		
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>Henry Correns</i>				<i>Satherine Stumpf</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
				<i>L. Shaw Jones, Masonic Home</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							<b>INTERVAL BETWEEN ONSET AND DEATH</b>
<b>200.1 IMMEDIATE CAUSE</b> (A) <i>Multiple Lympho-carcinoma</i>							<i>Oct. 29, 1955</i>
<b>ANTECEDENT CAUSE(S)</b> DUE TO							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b> (B)							
<b>STATING UNDERLYING CAUSE LAST,</b> DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)			<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>		
<b>22. I hereby certify that I attended the deceased from <i>June 2</i>, 19<i>54</i>, to <i>Jan 20</i>, 19<i>56</i>, that I last saw the deceased alive on <i>Jan 18</i>, 19<i>56</i>, and that death occurred at <i>8</i> <i>A.M.</i>, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <i>Walter T. Jones</i>				<b>ADDRESS</b> (Street, city, town, state)		<b>DATE SIGNED</b>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<i>BURIAL</i>		<i>1/23/56</i>		<i>LOUDON PARK CEMETERY</i>		<i>BALTIMORE, MARYLAND</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>Jan. 23, 1956</i>		<i>Frank L. Smith</i>		<i>Wm. Cook Inc</i>		<i>1217 ST. PAUL ST</i>	

# BUREAU V. S.

## CERTIFICATE OF DEATH

BUREAU V. S. DEPARTMENT OF HEALTH - BALTIMORE, MD.

DATE OF DEATH

AT WHAT RESIDENCE HOME OR PLACE

NAME OF DECEASED

PLACE OF DEATH

AT PLACE  
OR  
DEATH

IN MEDICAL CERTIFICATION

**BUREAU V. S.**

JAN 28 1936

**RECEIVED**

BUREAU V. S.

This certificate is to be filled out by the attending physician or other qualified person, and is to be filed in the Bureau of Vital Statistics, Baltimore, Maryland.

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00377

382

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Baltimore</i>		MARYLAND		STATE <i>Maryland</i> COUNTY <i>Carroll</i>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Cokeville</i>		<i>Nov. 5, 1941</i>		TOWN <i>Westminster, Md</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>90 Massie Home</i>				STREET ADDRESS (If rural give location) <i>31 Colonial Ave 06-27-3</i>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<i>George E. Sullivan</i>				<i>Jan 30 1956</i>			
<b>5. SEX</b>	<b>COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<i>M</i>	<i>White</i>	<i>Widowed</i>	<i>Nov. 7, 1867</i>	<i>88</i> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<i>Householder</i>		<i>Self</i>		<i>Westminster Md</i>		<i>U.S.A.</i>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<i>James Sullivan</i>				<i>Amelia Brown</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
		<i>-</i>		<i>Shaw Dennis Preysnell Md.</i>			
<b>18. MEDICAL CERTIFICATION</b>							
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>18a. IMMEDIATE CAUSE</b>		<b>(A)</b>		<b>18b. ANTECEDENT CAUSE(S)</b>		<b>DUE TO</b>	
<i>422.1</i>		<i>arterio sclerotic Cardiovascular disease</i>				<i>Nov 5, 1941 to Jan 30, 1956</i>	
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>		<b>(B)</b>		<b>DUE TO</b>			
<b>STATING UNDERLYING CAUSE LAST.</b>		<b>(C)</b>					
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>					
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town)</b>		<b>(County) (State)</b>	
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <i>Nov. 5, 1941</i>, to <i>Jan. 30, 1956</i>, that I last saw the deceased alive on <i>Jan. 30, 1956</i>, and that death occurred at <i>9:20 P.M.</i> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>ADDRESS (Street, city, town, state)</b>			
<i>Walter T. Kues</i>				<i>M.D.</i>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>		<b>DATE THEREOF</b>		<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county) (State)</b>	
<i>Burial</i>		<i>2/2/56</i>		<i>Kreider's Cemetery</i>		<i>Carroll County, Maryland</i>	
<b>24. REG'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>		<b>ADDRESS</b>	
<i>Feb. 4, 1956</i>		<i>Frank Smith</i>		<i>Wm Cook, Inc.</i>		<i>1517 St. Paul St</i>	



CERTIFICATE OF DEATH

283

1. NAME OF DECEASED

MARYLAND

2. PLACE OF DEATH

3. SEX

4. AGE

5. OCCUPATION

6. CAUSE OF DEATH

7. DATE OF DEATH

8. TIME OF DEATH

9. PLACE OF BURIAL

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF CLERGYMAN

16. SIGNATURE OF CHURCH

17. SIGNATURE OF FUNERAL HOME

18. SIGNATURE OF BURIAL

19. SIGNATURE OF INTERMENT

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172. SIGNATURE OF CHURCH

173. SIGNATURE OF FUNERAL HOME

174. SIGNATURE OF BURIAL

175. SIGNATURE OF INTERMENT

176. SIGNATURE OF RECORD

177. SIGNATURE OF INDEX

178. SIGNATURE OF FILE

179. SIGNATURE OF COPY

180. SIGNATURE OF RETURN

181. SIGNATURE OF DECEASED

182. SIGNATURE OF NEXT OF KIN

183. SIGNATURE OF CLERGYMAN

184. SIGNATURE OF CHURCH

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268. SIGNATURE OF CHURCH

269. SIGNATURE OF FUNERAL HOME

270. SIGNATURE OF BURIAL

271. SIGNATURE OF INTERMENT

272. SIGNATURE OF RECORD

273. SIGNATURE OF INDEX

274. SIGNATURE OF FILE

275. SIGNATURE OF COPY

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277. SIGNATURE OF DECEASED

278. SIGNATURE OF NEXT OF KIN

279. SIGNATURE OF CLERGYMAN

280. SIGNATURE OF CHURCH

281. SIGNATURE OF FUNERAL HOME



383

CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND	CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) <u>520</u>	STATE <u>Md.</u> COUNTY <u>Baltimore</u>	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Shady Nook Nursing Home</u>	LENGTH OF STAY (in this place) <u>3 mo.</u>	STREET ADDRESS (If rural give location) <u>740 Charing Cross Rd</u>	
3. NAME OF DECEASED: (First) <u>HARRY</u> (Middle) <u>B.</u> (Last) <u>Summers</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>1-25</u> <u>1956</u>	
5. SEX: <u>male</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>	8. DATE OF BIRTH: <u>7-28-1873</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Dr. Store</u>	9. AGE last birthday <u>82</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Mins.
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME: <u>James P. Summers</u>		14. MOTHER'S MAIDEN NAME: <u>Tabitha Buckingham</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>?</u>	
17. INFORMANT & ADDRESS: <u>Hospital Records.</u>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>CEREBRAL VASCULAR ACCIDENT</u>			
ANTECEDENT CAUSE (S) (B) <u>ARTERIOSCLEROTIC CARDIO- VASCULAR DISEASE</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (C) <u>TERMINAL PNEUMONIA</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	
21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/1/54</u> , 19 <u>54</u> to <u>1/25</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1/25</u> , 19 <u>56</u> , and that death occurred at <u>5:00 PM</u> from the causes and on the date stated above.			
SIGNATURE <u>John H. Sloan</u>		DATE SIGNED <u>1/26/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		DATE THEREOF <u>1-28-1956</u>	
NAME OF CEMETERY OR CREMATORY <u>Cripe Creek</u>		LOCATION (City, town, or county) (State) <u>Carroll Co Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-26-56</u>		REGISTRAR'S SIGNATURE <u>V.E. Harvey</u>	
24. FUNERAL DIRECTOR		ADDRESS <u>Edmondson Ave.</u>	

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JAN 30 1936

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

384

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

00379

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

Item 9, Film 9191 1-23-56 et

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>md</u> COUNTY <u>Balto</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Essex, Baltimore 2154</u>	
TOWN <u>Essex</u> LENGTH OF STAY (in this place) <u>8 months</u>		TOWN <u>Essex, Baltimore 2154</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>505 Essex Ave</u>		STREET ADDRESS (If rural give location) <u>505 Essex Ave</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna</u>	(First) <u>Agnes</u>	(Last) <u>SWEET</u>	4. DATE OF DEATH (Month) <u>12</u> (Day) <u>19</u> (Year) <u>56</u>
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>Feb 14 1889</u>
9. AGE last birthday <u>66</u> yrs.		10. BIRTHPLACE (State or foreign country) <u>md</u>	
11. BIRTHPLACE (State or foreign country) <u>md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George A Smith</u>		14. MOTHER'S MAIDEN NAME <u>Ann E Kirk</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY No. <u>214-34-2969</u>	
17. INFORMANT <u>Pauline Demond</u>		18. MEDICAL CERTIFICATION	

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

Metastatic carcinoma

INTERVAL BETWEEN ONSET AND DEATH

3 mo

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(b)

Carcinoma of stomach9 mo

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from Oct 24, 1955, to Jan 12, 1956, that I last saw the deceasedalive on Dec 29, 1955, and that death occurred at 7:30 P m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Cremation</u>	<u>1-16-1956</u>	<u>Silverbrook</u>	<u>Lanacaster Ave, Wil, Del</u>	
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS	
<u>1-14-56</u>	<u>Mrs Edith Hurley</u>	<u>Joseph A Grant</u>	<u>North East, Md</u>	

RECEIVED

JAN 18 1956

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

385

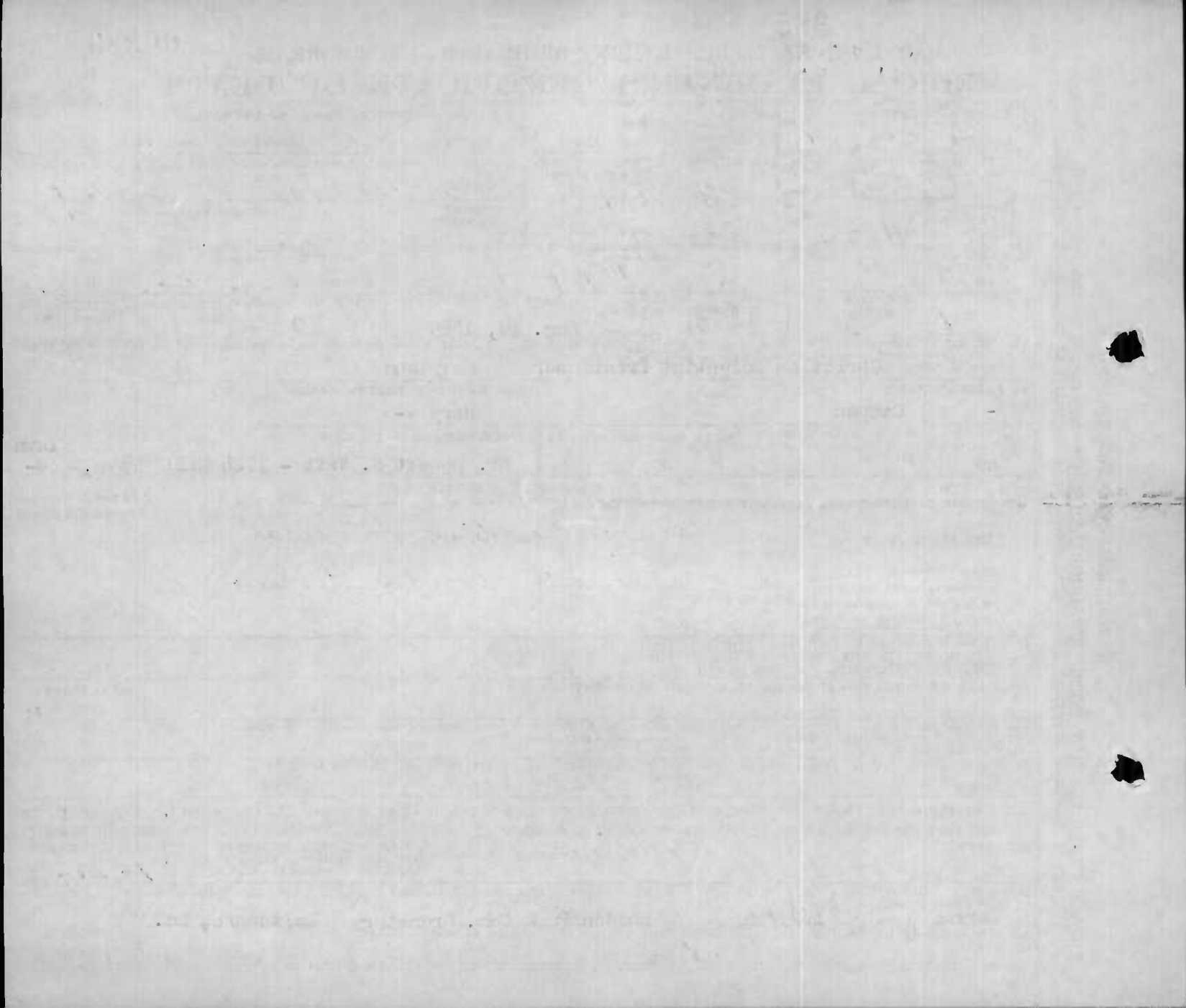
00380

Reg. Dist. No. 31

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

<b>1. PLACE OF DEATH:</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) OR			
TOWN <u>Brooklyn</u>		<u>7</u>		TOWN <u>Baltimore</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1724 Hill an</u>				STREET ADDRESS (If rural, give location) <u>1724 Hill an</u>			
3. NAME OF DECEASED: (First) <u>Leonor</u>		(Middle) <u>A</u>		(Last) <u>TAFT</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>July 19 56</u>	
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>		8. DATE OF BIRTH: <u>Aug. 17, 1885</u>		9. AGE last birthday: <u>70</u> yrs. <u>7</u> Months <u>1</u> Days <u>1</u> Hours <u>5</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Christian Scientist Practitioner</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>- Campen</u>				14. MOTHER'S MAIDEN NAME: <u>Mary --</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY No.: <u>no</u>		17. INFORMANT & ADDRESS: <u>Mr. Robert S. Taft - 1724 Hill Drive, Wood-</u>			
18. MEDICAL CERTIFICATION				INTERVAL BETWEEN ONSET AND DEATH			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
Immediate cause (a) <u>Acute cardiac failure</u> DUE TO Antecedent cause(s) (b) <u>Cardiovascular disease</u> Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>W. M. Kieffer</u>		1010 Leeds on		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>7-22-56</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
M. D. ASSISTANT MEDICAL EXAM. <u>1-22-56</u>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF: <u>1/23/56</u>		NAME OF CEMETERY OR CREMATORY: <u>Loudon Park Cem. Crematory</u>		LOCATION (City, town, or county) (State): <u>Baltimore, Md.</u>	
DATE REC'D BY LOCAL REG. <u>1/23/56</u>		REGISTRAR'S SIGNATURE: <u>W. M. Kieffer</u>		24. FUNERAL DIRECTOR: <u>Wm. J. Lickner &amp; Sons - Baltimore, Md.</u>		ADDRESS:	





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## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Baltimore</u> MARYLAND		STATE <u>Maryland</u> COUNTY <u>Prince George</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>T.B.</u> <u>16x-2</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 Spring Grove State Hospital</u>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year) OF DEATH:	
<u>William</u> <u>Joseph</u> <u>Tebbs</u>		<u>January 17,</u> <u>19 56</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:
<u>Male</u>	<u>White</u>	<u>Separated</u>	<u>11-2-1891</u>
9. AGE last birthday		IF UNDER 1 YEAR IF UNDER 24 HRS.	
<u>64</u> yrs.		Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:	
<u>Steam Plumber</u>		<u>New York</u>	
11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>USA</u>		<u>USA</u>	
13. FATHER'S NAME:		14. MOTHER'S MAIDEN NAME:	
<u>William Charles Tebbs</u>		<u>Martinie Donelson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
<u>Unknown</u>		<u>Unknown</u>	
17. INFORMANT & ADDRESS:		<u>Records Spring Grove State Hospital</u>	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <u>420.1 Coronary thrombosis</u>			
ANTECEDENT CAUSE (S) DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. (B) <u>Chronic cardiac failure</u>			
(C) <u>Arteriosclerotic cardiovascular disease</u>		<u>Years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
<u>0</u>			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>7</u> ....., 19 <u>53</u> to <u>1-17</u> ....., 19 <u>56</u> that I last saw the deceased alive on <u>1-17</u> ....., 19 <u>56</u> , and that death occurred at <u>10 P.</u> M., from the causes and on the date stated above.			
SIGNATURE <u>Stella Wachler</u>		DATE SIGNED <u>1-18-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		NAME OF CEMETERY OR CREMATION <u>Arlington Cemetery</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-18-56</u>		REGISTRAR'S SIGNATURE <u>T.E. Harris</u>	
24. FUNERAL DIRECTOR <u>Martin W. Hyung Co</u>		ADDRESS <u>Spring Grove State Hospital</u>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 20 1956

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# 387

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

### MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 00382

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u> MARYLAND				STATE <u>md</u> COUNTY <u>Baltimore</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
TOWN <u>Middle River</u>				TOWN <u>Middle River</u> 54			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>950 Bengies Road</u>				STREET ADDRESS (If rural, give location) <u>950 Bengies Road</u>			
3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<u>MARtha</u> <u>Thomas</u>				<u>1 - 2</u> 19 <u>66</u>			
5. SEX: <u>+</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>married</u>	8. DATE OF BIRTH: <u>JULY 15 - 1886</u>		9. AGE last birthday: <u>75</u> yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Greensboro N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME: <u>Sandy Winchester</u>				14. MOTHER'S MAIDEN NAME: <u>Ada Van Kester</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <u>James Thomas 930 Bengies Road</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
442x Immediate cause		(a) <u>Hypertensive Cardio-Vascular</u>					
Antecedent cause(s)		DUE TO (b) <u>Renal Disease</u>					
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last		DUE TO (c)					
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY		21c. (City or town) (County)		(State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>M.B. Davis M.D.</u>		CHIEF MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		DATE SIGNED <u>1/24/66</u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>		DATE THEREOF <u>Jan 25/66</u>		NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		LOCATION (City, town, or county) (State) <u>A.A. County Md.</u>	
DATE REC'D BY LOCAL REG. <u>3-55</u>		REGISTER'S SIGNATURE <u>Dr. Hedrick</u>		FUNERAL DIRECTOR <u>Mrs. Robert G. Elliott, Daughter</u>		ADDRESS <u>1129 N. Caroline St</u>	

22800  
RECEIVED  
JAN 10 1882

My dear Sir,  
I have the honor to acknowledge the receipt of your letter of the 2nd inst. in relation to the matter of the  
J. J. Smith & Co. and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,  
Yours,  
J. J. Smith & Co.

Very truly,  
J. J. Smith & Co.

211

## CERTIFICATE OF DEATH

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

COUNTY Baltimore MARYLAND  
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Arbutus  
HOSPITAL OR INSTITUTION OR STREET ADDRESS 4307 Wilkens Ave

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Baltimore  
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Arbutus  
STREET ADDRESS 4307 Wilkens Ave

## 3. NAME OF DECEASED:

(First) (Middle) (Last)  
Dr. John Frederick Timmes

4. DATE OF DEATH: (Month) (Day) (Year)  
Jan. 21, 1956

## 5. SEX:

male

## 6. COLOR OR RACE:

White

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED:

Married

## 8. DATE OF BIRTH:

June 29, 1877

## 9. AGE last birthday:

78

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

## 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Med. Doctor

## 10b. KIND OF BUSINESS OR INDUSTRY:

Self

## 11. BIRTHPLACE (State or foreign country):

Brooklyn, N.Y.

## 12. CITIZEN OF WHAT COUNTRY?

## 13. FATHER'S NAME:

John Timmes

## 14. MOTHER'S MAIDEN NAME:

Barbara Hafer

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

none

## 17. INFORMANT &amp; ADDRESS:

Marie Timmes, 4307 Wilkens Ave

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

## Immediate cause

(a) DUE TO

## Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION:

INTERVAL BETWEEN ONSET AND DEATH

6 months

## 21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while work at work

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from July 1953, to Jan. 21, 1956, that I last saw the deceased alive on 1/17, 1956, and that death occurred at 8:04 a.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE)

ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

ADDRESS

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JAN 23 1956

BUREAU V. S.



1

## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00384

388

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <b>BALTIMORE</b>		STATE <b>MARYLAND</b>		COUNTY			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT HOWARD</b>		<b>21 DAYS</b>		TOWN <b>BALTIMORE</b>		<b>3Y01-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>VETERANS ADMINISTRATION HOSPITAL</b>				STREET ADDRESS (If rural give location) <b>4118 COLEMAN AVENUE</b>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<b>MARK</b> (First)		<b>D. TRACY</b> (Middle) (Last)		<b>January 17</b> (Month) (Day)		<b>19 56</b> (Year)	
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>		<b>IF UNDER 24 HRS.</b>
<b>Male</b>	<b>White</b>	<b>Married</b>	<b>October 26, 1896</b>	<b>59</b> yrs.	Months	Days	Hours Min.
<b>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b>			<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b>
<b>Mechanic</b>			<b>Automobile</b>		<b>Rushford, Minnesota</b>		<b>U. S. A.</b>
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<b>Michael Tracy</b>				<b>Ellen Hennesey</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)</b>			<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>		
<b>Yes</b>			<b>213-12-8987</b>		<b>Clin. Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>		
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>196X</b> IMMEDIATE CAUSE (A) <b>CHONDROSARCOMA, LEFT HIP WITH METASTASIS TO</b>						INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSE(S) <b>XXXXX</b> <b>LUNGS AND HEART</b>						<b>3 MONTHS</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b>	
<b>11/15/55</b>		<b>Disarticulation left leg</b>				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While at work Not while at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
		<b>M. at work</b>					
<b>22. I hereby certify that I attended the deceased from Dec. 27, 1955, to Jan. 17, 1956, and that death occurred at 11:35 PM, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<b>Donald D. Mark, M. D.</b>				<b>1/18/56</b>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>NAME OF CEMETERY OR CREMATORY</b>		<b>LOCATION (City, town, or county)</b>	
<b>Burial</b>				<b>Holy Redeemer Cemetery</b>		<b>Baltimore, Maryland</b>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<b>DATE</b>		<b>Jan. 19, 1956</b>		<b>Wm. Cook-Blight, Inc., 6009 Harford Rd., Balto. Md.</b>			

BUREAU V. S.

JAN 20 1956

RECEIVED

389

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u> COUNTY			
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>62 Catonsville</u>		LENGTH OF STAY (in this place) <u>3yrs. 10dys.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Baltimore/Catonsville</u> Washington D. C.			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>14 SPRING GROVE STATE HOSP.</u>				STREET ADDRESS <u>220 Colorado Bldg. Mercy Villa / Baltimore, Md.</u> 47X-3			
3. NAME OF DECEASED: (First) <u>Ida</u>		(Middle) <u>Elizabeth</u>		(Last) <u>Tyler</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>Jan. 25 1956</u>	
5. SEX: <u>female</u>	6. COLOR OR RACE: <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>	8. DATE OF BIRTH: <u>Feb. 28, 1873</u>	9. AGE last birthday: <u>82</u> yrs.	IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>housekeeper</u>			10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME: <u>William Tyler</u>				14. MOTHER'S MAIDEN NAME: <u>Frances</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>unknown</u> If Yes, give war or dates of service		16. SOCIAL SECURITY NO. <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Spring Grove Hospital records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <u>Bronchopneumonia</u>							
ANTECEDENT CAUSE (S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST (B) <u>Chronic cardiovascular disease</u>							
(C) <u>Generalized arteriosclerosis</u>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>2</u>		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July, 1953</u> , to <u>Jan. 25, 1956</u> , that I last saw the deceased alive on <u>1/4/56</u> , and that death occurred at <u>1/4/56</u> M, from the causes and on the date stated above.							
SIGNATURE <u>Joseph P. Cowen</u>		ADDRESS <u>SPRING GROVE STATE HOSP., Catonsville 28 Md.</u>		DATE SIGNED <u>1/25/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>2/16/56</u>		NAME OF CEMETERY OR CREMATORY <u>Spring Grove State Hosp. Catonsville 28 Md.</u>		LOCATION (City, town, or county) (State)	
DATE REC'D BY LOCAL REGISTRAR <u>2/16/56</u>		REGISTRAR'S SIGNATURE <u>T.E. Harry</u>		24. FUNERAL DIRECTOR <u>Spring Grove State Hosp Catonsville 28 Md.</u>		ADDRESS	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

FEB 20 1951

BUREAU

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

00385

## 390 CERTIFICATE OF DEATH

Reg. Dist. No. 33

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Owings Mills</b>		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <b>Owings Mills</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Pleasant Hill Road</b>				STREET ADDRESS (If rural give location) <b>Pleasant Hill Road</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>John Conrad Uhler</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>Jan. 18 19 56</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Married</b>	8. DATE OF BIRTH <b>Jan. 1, 1871</b>	9. AGE last birthday <b>85</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Western Md. R.R.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore County</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Charles Uhler</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Lorey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>No</b>		16. SOCIAL SECURITY NO. <b>705-10-7387</b>		17. INFORMANT & ADDRESS <b>Elizabeth H. Uhler, Owings Mills, Md.</b>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
450.1 IMMEDIATE CAUSE (A) <b>Gangrene of both feet</b>						3 mos.	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Generalized arteriosclerosis</b>						8 years	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Prostatic hypertrophy with urinary retension</b>						3 days	
19a. DATE OF OPERATION <b>none</b>		19b. MAJOR FINDINGS OF OPERATION <b>none</b>		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) <b>none</b>		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) <b>none</b>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <b>none</b>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> <b>none</b>		21f. HOW DID INJURY OCCUR? <b>none</b>			
22. I hereby certify that I attended the deceased from <b>June 30, 1939</b> , to <b>Jan. 18, 1956</b> , that I last saw the deceased alive on <b>Jan. 17, 1956</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above.							
SIGNATURE <b>D. D. Epling</b>				DATE SIGNED <b>6 Hanover Rd., Reisterstown, Md. 1-19-56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>Jan. 21, 1956</b>		NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
24. REC'D BY REGISTRAR DATE <b>1-20-55</b>		REGISTRAR'S SIGNATURE <b>Mary B. Eline</b>		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>J.F. Eline &amp; Sons, Reisterstown, Md.</b>			



# HAWAIIAN STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

## CERTIFICATE OF DEATH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

NAME OF DECEASED

AGE

SEX

RACE

EDUCATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

BUREAU V. S.

JAN 28 1956

RECEIVED



CERTIFICATE OF DEATH

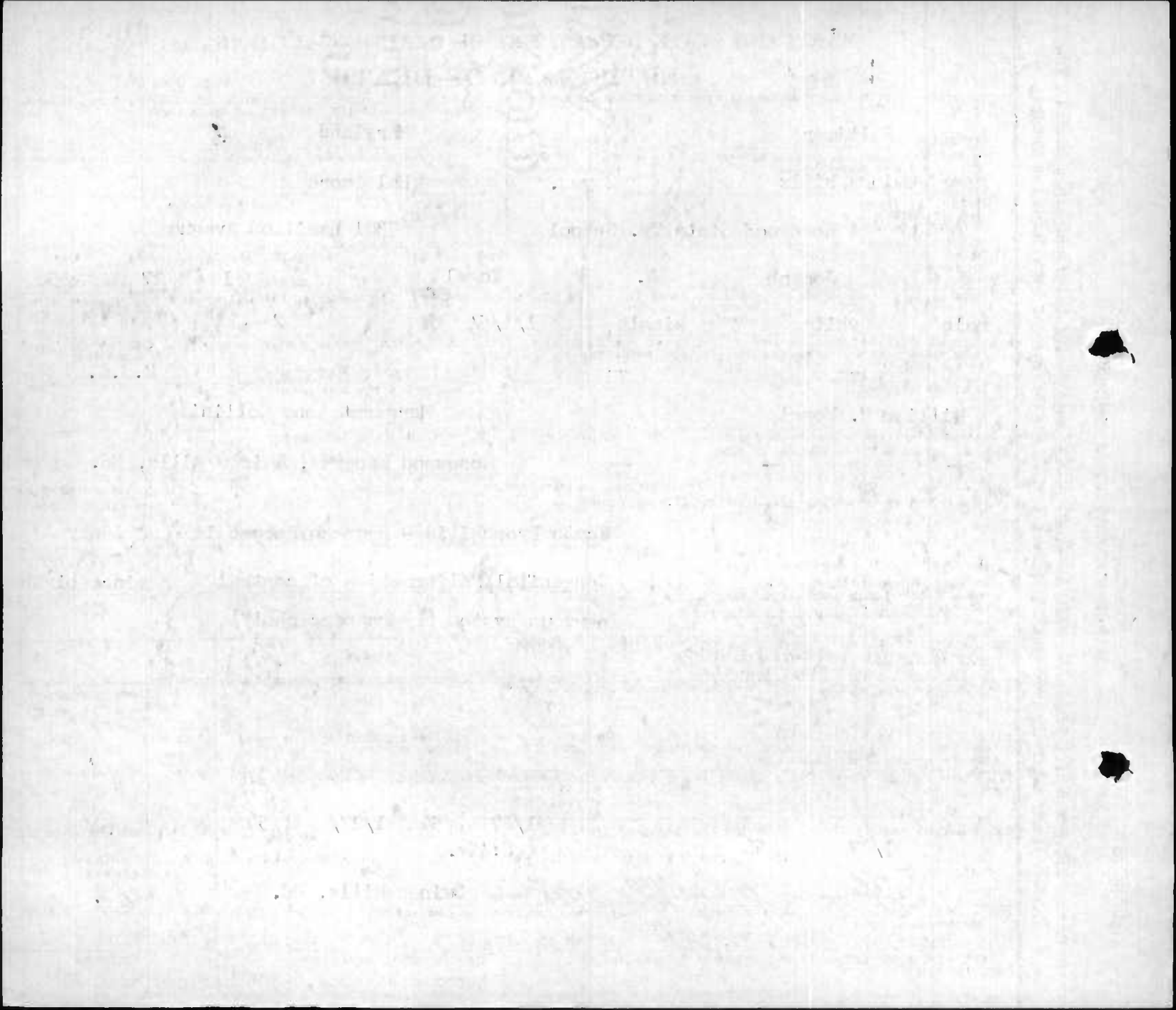
Reg. Dist. No. 33

391

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR		TOWN <b>Baltimore</b>	
TOWN <b>Owings Mills</b>		<b>2 yrs.</b>		STREET ADDRESS (If rural give location)		<b>3301 Hamilton Avenue</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Rosewood State Tr. School</b>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<b>Joseph N. Vogel</b>				<b>1 27 19 56</b>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<b>male</b>	<b>white</b>	<b>single</b>	<b>1/1/54</b>	<b>2 yrs.</b>	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
						<b>Baltimore, Maryland</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>William H. Vogel</b>				<b>Margaret Anne Cellini</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
						<b>Rosewood Records, Owings Mills, Md.</b>	
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>Acute Bronchitis - Broncho Pneumonia</b>						<b>1 day</b>	
ANTECEDENT CAUSE (B) <b>Congenital Malformation of central nervous system (hydroanencephaly)</b>						<b>since birth</b>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<b>0</b>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY				21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>1/27</b> , 19 <b>56</b> , to <b>1/27/</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>1/27</b> , 19 <b>56</b> and that death occurred at <b>8:40a</b> M, from the causes and on the date stated above.							
SIGNATURE <b>Harry S. Butler, M.D.</b>				ADDRESS <b>Owings Mills, Md.</b>		DATE SIGNED <b>1/27/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Jan. 30, 1956</b>		<b>Parkwood Cemetery</b>		<b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>1-3056</b>				<b>Leonard J. Ruck, 5305 Harford Road #14</b>			

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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CERTIFICATE OF DEATH

Reg. Dist. No.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>BALTIMORE</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY	
CITY (If outside corporate limits, write RURAL or and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
<b>FORT HOWARD</b>		<b>109 DAYS</b>		<b>BALTIMORE</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>VETERANS ADMINISTRATION HOSPITAL</b>				<b>318 SOUTH WASHINGTON STREET</b>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<b>JOHN F. WANTROBE</b>				<b>JANUARY 18 19 56</b>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<b>Male</b>		<b>White</b>		<b>Single</b>		<b>June 14, 1896</b>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<b>59 yrs.</b>		Months Days		Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<b>Zinc smelter</b>				<b>Steel Company</b>		<b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY?							
<b>U. S. A.</b>							
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>Frank Wantrobe</b>				<b>Margaret MN: Unknown</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>Yes</b>				<b>WW I</b>		<b>Unknown</b>	
18. MEDICAL CERTIFICATION				19. INTERVAL BETWEEN ONSET AND DEATH			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <b>BRONCHOGENIC CARCINOMA, RIGHT UPPER LOBE</b>				<b>1 1/2 YEARS</b>			
ANTECEDENT CAUSE (B)							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
<b>VA</b>		<b>M.</b>					
22. I hereby certify that I attended the deceased from <b>Oct. 1, 1955</b> , to <b>Jan. 1956</b> , and that death occurred at <b>2:40 PM</b> , from the causes and on the date stated above.							
SIGNATURE <b>Donald D. Mark, M.D.</b>				ADDRESS <b>VAH, FORT HOWARD, MARYLAND</b>		DATE SIGNED <b>1/19/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1/23/56</b>		<b>St. Stanislaus Cemetery</b>		<b>Baltimore, Maryland</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>20-56</b>		<b>Dr. Redner</b>		<b>Michael A. Sadowski</b>		<b>1808 Eastern Ave. Baltimore, Md.</b>	

MARGIN RESERVED FOR BINDING

THE BOARD OF DIRECTORS OF THE  
AMERICAN ASSOCIATION OF  
UNIVERSITY AND COLLEGE TEACHERS



AMERICAN ASSOCIATION OF  
UNIVERSITY AND COLLEGE  
TEACHERS

ACADEMIC STANDARDS

ACADEMIC STANDARDS

00388

MARYLAND

393

STATE DEPARTMENT OF HEALTH

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Baltimore</u> COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Lutherville</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
TOWN <u>rural</u>		TOWN <u>Baltimore</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>College Manor</u>		STREET ADDRESS (If rural, give location) <u>Northway apt. 3700 n. Charles St.</u>	
3. NAME OF DECEASED (Type or Print) <u>Anna C. E. Wehr</u>		4. DATE OF DEATH (Month) <u>Jan.</u> (Day) <u>7</u> (Year) <u>1956</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) <u>widowed</u>	8. DATE OF BIRTH <u>Jan 20 1879</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>76</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>Balto. City</u>	
13. FATHER'S NAME <u>Martin Meyerdirek</u>		14. MOTHER'S MAIDEN NAME <u>Meyerdirek, Anna Felber</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No. <u>                    </u>	
17. INFORMANT AND ADDRESS <u>Helen W. Bartlett, daughter, Easton, Md</u>			

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170 X

Immediate cause

(a)

metastatic carcinoma

Antecedent cause(s)

(b)

carcinoma of breast

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 1/6, 1956, to 1/7, 1956, that I last saw the deceasedalive on 1/6, 1956, and that death occurred at 3:00 p.m., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county)	(State)
<u>Burial</u>	<u>Jan. 9, 1956</u>	<u>Druid Ridge</u>	<u>Pikesville</u>	<u>Md</u>

DATE REC'D BY LOCAL REG.

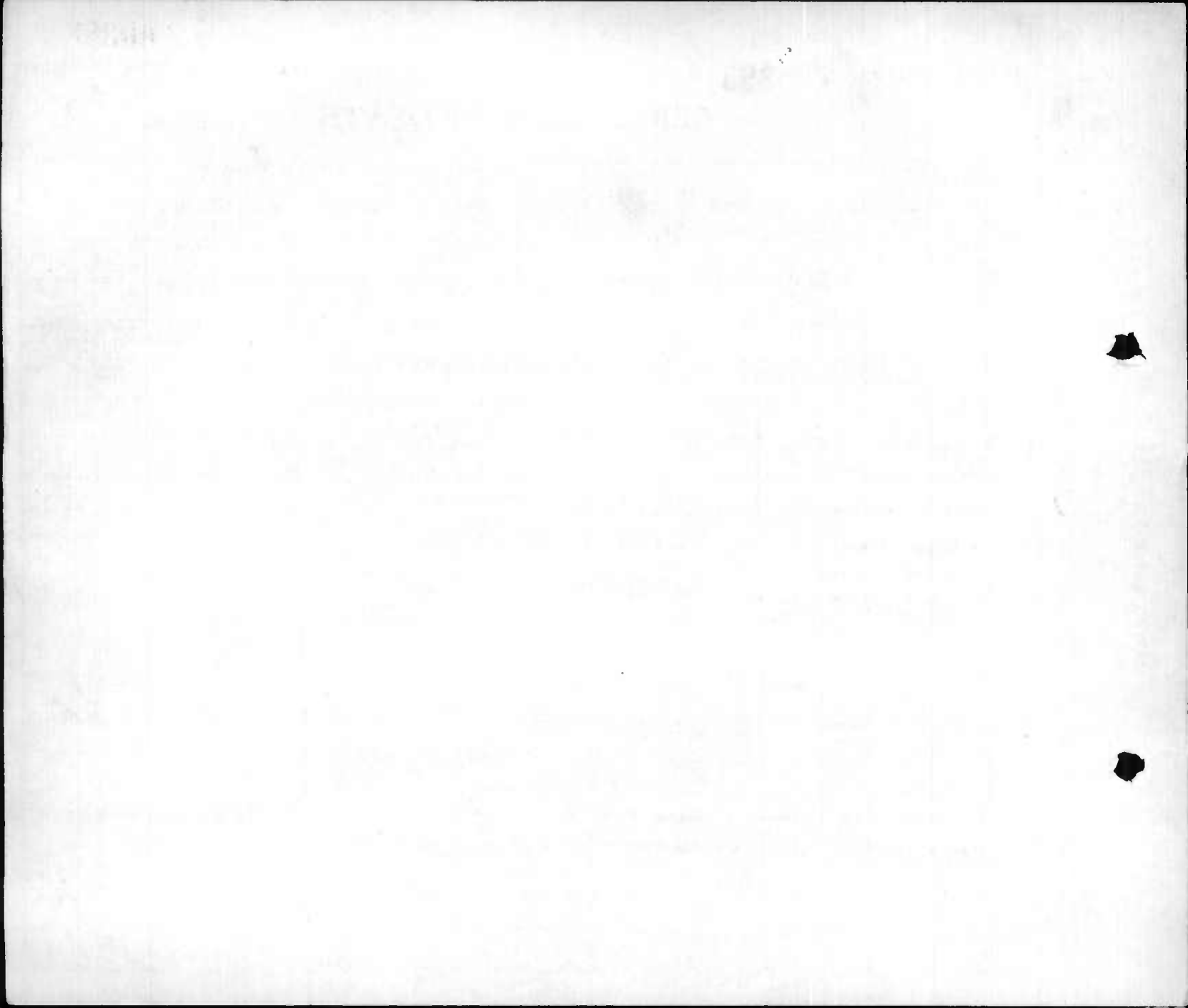
REGISTRAR'S SIGNATURE

FUNERAL DIRECTOR

ADDRESS

1/9/56Augustus H. H. H.Wm. J. Fisher & Sons - Balto 17 Md.

MARGIN RESERVED FOR BINDING





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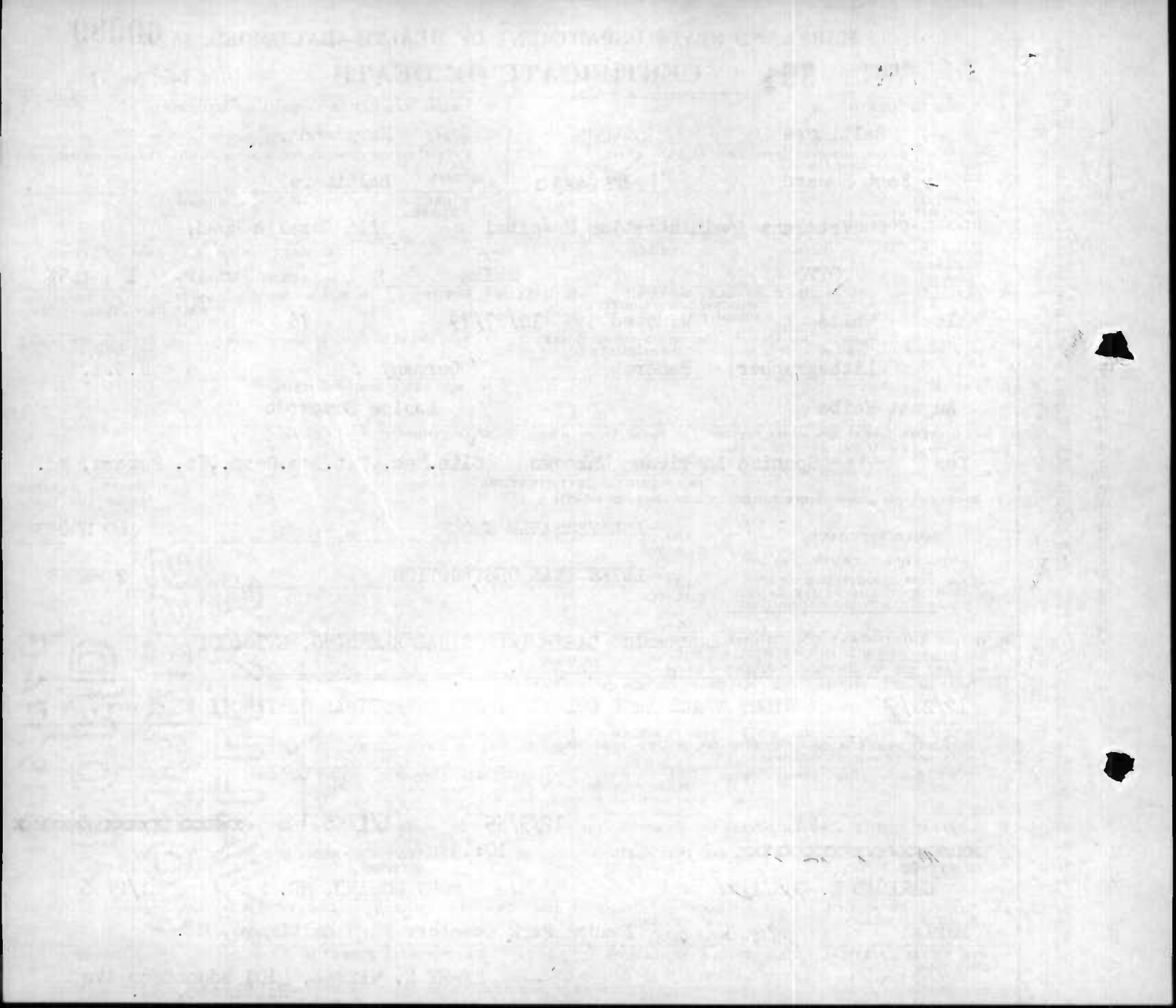
CERTIFICATE OF DEATH

Reg. Dist. No. 44

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <b>Baltimore</b>		MARYLAND		STATE <b>Maryland</b>		COUNTY <b>Baltimore</b>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN			
<b>Fort Howard</b>		<b>27 days</b>		<b>Baltimore</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>Veterans Administration Hospital</b>				<b>3216 Rosalie Road,</b>			
3. NAME OF DECEASED: (Type or Print)		(First)		(Middle)		(Last)	
<b>OTTO</b>				<b>WEIBE</b>			
4. DATE (Month) OF DEATH:		(Day)		(Year)			
<b>January</b>		<b>1</b>		<b>1956</b>			
5. SEX:		6. COLOR OR RACE:		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):		8. DATE OF BIRTH:	
<b>Male</b>		<b>White</b>		<b>Widowed</b>		<b>10/27/79</b>	
9. AGE last birthday		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
<b>76 yrs.</b>		<b>Months</b>		<b>Days</b>		<b>Hours</b>	
						<b>Min.</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):				10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):	
<b>Lithographer</b>				<b>Paper</b>		<b>Germany</b>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<b>August Weibe</b>				<b>Louise Bombardt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:	
<b>Yes</b>				<b>Spanish American Unknown</b>		<b>Clin.Rec., Vet. Adm. Hosp., Ft. Howard, Md.</b>	
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE				(A) <b>IRREVERSABLE SHOCK</b>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <b>INTESTINAL OBSTRUCTION</b>			
				DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>GASTROINTESTINAL BLEEDING, ETIOLOGY UNKNOWN.</b>							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
<b>12/28/55</b>		<b>RIGHT TRANSVERSE COLOSTOMY FOR INTESTINAL OBSTRUCTION</b>					
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR?		(County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>12/5/55</b> , 19... to <b>1/1/56</b> , 19..., and that death occurred at <b>10:15 PM</b> , from the causes and on the date stated above.							
SIGNATURE				ADDRESS		DATE SIGNED	
<b>CARIDAD E. GONZALEZ</b>				<b>M. D. FORT HOWARD, MD.</b>		<b>1/2/56</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>Jan. 5/56</b>		<b>Loudon Park Cemetery</b>		<b>Baltimore, Md.</b>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<b>1-4-55</b>		<b>Harry H. Witzke</b>		<b>HARRY H. WITZKE</b>		<b>1101 Edmondson Ave Baltimore, Md.</b>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

395

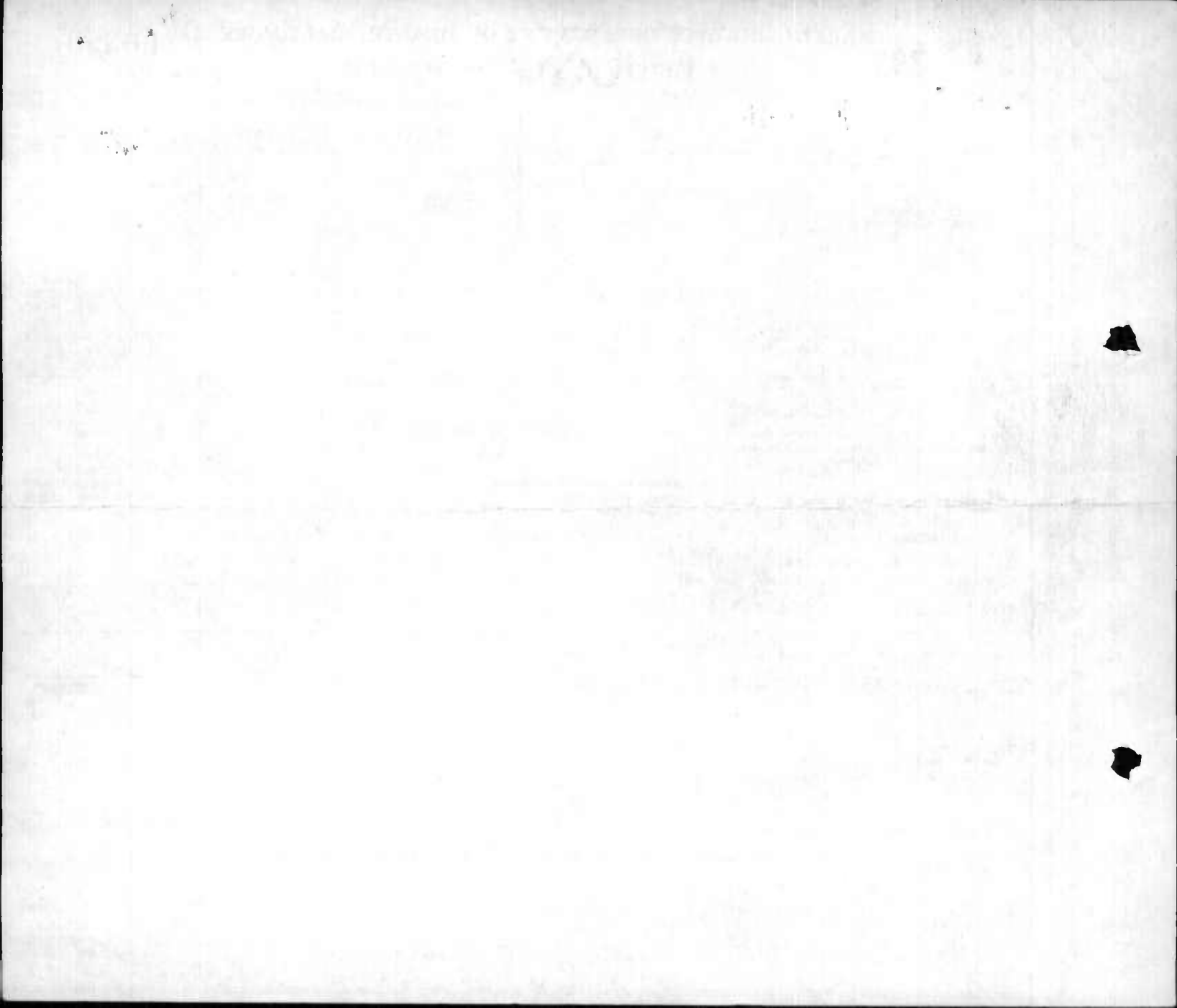
Item 2, Film 101-1-2-56 et

00390

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>MD</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
52 TOWN <u>Urbansville</u>		12 years		OR TOWN <u>Baltimore</u>		3101.4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
14 <u>Spring Grove St. Hosp.</u>				<u>BALTIMORE, MD. 120 N. Fremont Ave.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
DECEASED: (Type or Print) <u>Mary A. West</u>				OF DEATH: <u>1</u> <u>13</u> <u>1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>F</u>	<u>W</u>	<u>Single</u>	<u>1874</u>	<u>82</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
				<u>MD.</u>		<u>U.S.</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Mr. Roun</u>				<u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS:			
		<u>—</u>		<u>Hospital records</u>			
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
157X IMMEDIATE CAUSE				(A) <u>Carcinoma of Pancreas</u>			
ANTECEDENT CAUSE (S)				DUE TO			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) DUE TO			
				(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION					
20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State)		INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6/30, 1948</u> , to <u>1/13, 1956</u> , that I last saw the deceased alive on <u>1/13, 1956</u> , and that death occurred at <u>10:55 PM</u> , from the causes and on the date stated above.							
SIGNATURE		ADDRESS		DATE SIGNED			
<u>Stella Wachler</u>		<u>Spring Grove St. Hosp.</u>		<u>1/16/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>usual</u>		<u>Jan 15/56</u>		<u>Cathedral</u>		<u>Baltimore</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>1-15-56</u>		<u>[Signature]</u>		<u>Stewart-Morris</u>		<u>Balto.</u>	



MARYLAND

00391  
STATE DEPARTMENT OF HEALTH

396

## CERTIFICATE OF DEATH

Reg. Dist. No. 91

1. PLACE OF DEATH COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Restonstown</u> TOWN <u>Restonstown</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Baltimore</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Restonstown</u> TOWN <u>Restonstown</u> STREET ADDRESS (If rural, give location) <u>Deer Park Rd.</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>JAMES</u> <u>LEWIS</u> <u>WHALEN</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>January</u> <u>30</u> <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 17, 1872</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Business</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Und.</u>	9. AGE last birthday <u>83</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Wesley E. Whalen</u>		14. MOTHER'S MAIDEN NAME <u>Janice Walker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT AND ADDRESS <u>Mrs. Lura Whalen, Restonstown, Md.</u>			

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Arteriosclerosis, generalized, severe</u>		(b) <u>especially cerebral</u>	<u>2 years</u>
Antecedent cause(s) (c) <u>giving rise to the above cause stating the underlying cause last</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from December, 1955, to Jan 30, 1956, that I last saw the deceased

alive on Jan 26, 1956, and that death occurred at 12:00 A.M., from the causes and on the date stated above.

SIGNATURE Charles E. McWilliam, M.D. (Degree or title) ADDRESS Restonstown, Maryland DATE SIGNED Jan 30, 1956

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>2-1-56</u>	NAME OF CEMETERY OR CREMATORY <u>Deer Park</u>	LOCATION (City, town, or county) (State) <u>Deer Park, Balto Co., Md.</u>
DATE REC'D BY LOCAL REG. <u>Jan. 31, 1956</u>	REGISTRAR'S SIGNATURE <u>Mr. E. Martin</u>	24. FUNERAL DIRECTOR <u>Quint H. Knight - Hypherville, Md.</u>	ADDRESS

MARGIN RESERVED FOR BINDING

RECEIVED

FEB 1 1956

BUREAU V. S.



## CERTIFICATE OF DEATH

Reg. Dist. No. 38

1. PLACE OF DEATH: COUNTY <u>Balto.</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>52 Catonsville</u> TOWN <u>Catonsville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>902 Edmondson Ave.</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Balto.</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>52 Catonsville</u> STREET ADDRESS (If rural give location) <u>902 Edmondson Ave.</u>	
3. NAME OF DECEASED: (First) <u>AMOS</u> (Middle) <u>WILLIAMS</u> (Last)		4. DATE (Month) (Day) (Year) OF DEATH: <u>JAN. 3, 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>	8. DATE OF BIRTH: <u>July 15, 1887</u>
9. AGE last birthday <u>68</u> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min. IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Cook</u>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Catonsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Charles Williams</u>		14. MOTHER'S MAIDEN NAME: <u>Agnes Harriday</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Benjamin Williams 2 Milbert Ave.</u>			
18. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (A) <u>Mitral Insufficiency</u>		<u>8mo-25d</u>	
ANTECEDENT CAUSE (S) <u>Hypertensive Arteriosclerosis</u>		<u>?</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
22. I hereby certify that I attended the deceased from <u>4-12-</u> , 19 <u>55</u> to <u>1-3</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>1-3-</u> , 19 <u>56</u> , and that death occurred at <u>11:03 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>Est. Maloney</u>		DATE SIGNED <u>1-4-56</u>	
M. D. <u>57 W. Baltimore Baltimore</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 7, 1956</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Hilary Cem.</u>		LOCATION (City, town, or county) (State) <u>Cella Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>1-6-56</u>		REGISTRAR'S SIGNATURE <u>W. Hedz...</u>	
24. FUNERAL DIRECTOR <u>Mr. Kate R. Williams</u>		ADDRESS <u>322 N. Schroeder St.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CERTIFICATE OF DEATH

THIS IS TO CERTIFY THAT

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

RELIGION OF DECEASED

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CHURCH

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF CLERK

NAME OF JUDGE

NAME OF SHERIFF

NAME OF DEPUTY SHERIFF

NAME OF CONSTABLE

NAME OF JURY

NAME OF VERDICT

NAME OF SENTENCE

NAME OF EXECUTION

NAME OF BURIAL

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF CLERK

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

RELIGION OF DECEASED

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CHURCH

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF CLERK

NAME OF JUDGE

NAME OF SHERIFF

NAME OF DEPUTY SHERIFF

NAME OF CONSTABLE

NAME OF JURY

NAME OF VERDICT

NAME OF SENTENCE

NAME OF EXECUTION

NAME OF BURIAL

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF CLERK

NAME OF JUDGE

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE OF DECEASED

SEX OF DECEASED

EDUCATION OF DECEASED

OCCUPATION OF DECEASED

RELIGION OF DECEASED

DATE OF BURIAL

PLACE OF BURIAL

NAME OF MINISTER

NAME OF CHURCH

NAME OF FUNERAL HOME

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF CLERK

NAME OF JUDGE

NAME OF SHERIFF

NAME OF DEPUTY SHERIFF

NAME OF CONSTABLE

NAME OF JURY

NAME OF VERDICT

NAME OF SENTENCE

NAME OF EXECUTION

NAME OF BURIAL

NAME OF INTERVIEWER

NAME OF WITNESS

NAME OF CLERK

NAME OF JUDGE

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## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

COUNTY Baltimore

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town) Catonsville

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS 408 Thackery Ave

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Baltimore

CITY (If outside corporate limits, write RURAL and give nearest town) OR Catonsville

STREET ADDRESS (If rural, give location) 408 Thackery Ave

## 3. NAME OF DECEASED:

(First) (Middle) (Last) Stephen Yovanov

4. DATE OF DEATH: (Month) (Day) (Year) Jan. 19, 1956

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: May 7, 1916

9. AGE last birthday: 39 yrs. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Self

11. BIRTHPLACE (State or foreign country): Baltimore, Md.

12. CITIZEN OF WHAT COUNTRY? US

## 13. FATHER'S NAME:

Dushon Yovanov

## 14. MOTHER'S MAIDEN NAME:

?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) none

(If Yes, give war or dates of service) none

16. SOCIAL SECURITY No.: 216-01-9428

17. INFORMANT &amp; ADDRESS: Margaret H. Yovanov, 408 Thackery Ave.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1 Immediate cause

(a) DUE TO

Antecedent cause(s)

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b) DUE TO

(c)

Coronary Embolism

Coronary Disease

INTERVAL BETWEEN ONSET AND DEATH

12 hr

4 yrs?

## II. OTHER SIGNIFICANT CONDITIONS:

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION:

## 20. AUTOPSY?

Yes ☐ No ☐

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Not while M. work ☐ at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12:26, 1955, to 1:19, 1956, that I last saw the deceased alive on 1:19, 1956, and that death occurred at 10:45 p.m., from the causes and on the date stated above.

SIGNATURE

(DEGREE OR TITLE) ADDRESS

DATE SIGNED

## 23. BURIAL, CREMATION REMOVAL (Specify):

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REG.

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

Burial

1-23-56

Loudon Park

Baltimore, Md.

1-21-56

V.E. Harry

Howard H. Hubbard, 4107 Wilkens Ave.

MARGIN RESERVED FOR BINDING

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Mr. DeLoach  
805 - President 720

BUREAU V. S.

JAN 24 1956

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

01567

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## CERTIFICATE OF DEATH

Reg. Dist. No. 40

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Baltimore</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <u>Sweet Air (Baldwin P.O.)</u>				TOWN <u>Sweet Air (Baldwin P.O.)</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Green Rd. near Paper Mill Rd.</u>				STREET ADDRESS (If rural give location) <u>Green Rd. near Paper Mill Rd.</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Carrie Irene Zinkhan</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>Jan. 24, 1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>		8. DATE OF BIRTH <u>Jan. 12, 1877</u>	
						9. AGE last birthday <u>79</u> yrs.	
						IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>John Young</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>None</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Chas. Zinkhan, Baldwin, Md.</u>	
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							<b>INTERVAL BETWEEN ONSET AND DEATH</b>
IMMEDIATE CAUSE (A) <u>Coronary occlusion</u>							<u>immediate</u>
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterial sclerosis</u>							<u>20 yrs.</u>
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Arthritis</u>							<u>5 yrs.</u>
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>P.O.</u> , 19 <u>56</u> , to <u>Medical Examiner notified</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Jan. 24, 1956</u> , and that death occurred at <u>9 A.M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>William A. Tyson M.D.</u>				ADDRESS (Street, city, town, state) <u>Kingville, Md.</u> DATE SIGNED <u>Jan. 24, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Jan. 27, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Prospect Hill Cemetery</u>		LOCATION (City, town, or county) (State) <u>Towson, Maryland</u>	
24. REC'D BY REGISTRAR <u>1-29-56</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>John Burns' Sons</u>		ADDRESS <u>Towson, Maryland</u>	

# CERTIFICATE OF DEATH

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1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Age at death

6. Sex

7. Race

8. Marital status

9. Occupation

10. Education

11. Date of birth

12. Date of death

13. Date of death

14. Date of death

15. Date of death

16. Date of death

17. Date of death

18. Date of death

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29. Date of death

30. Date of death

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Age at death

6. Sex

7. Race

8. Marital status

9. Occupation

10. Education

11. Date of birth

12. Date of death

13. Date of death

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1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Age at death

6. Sex

7. Race

8. Marital status

9. Occupation

10. Education

11. Date of birth

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1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Age at death

6. Sex

7. Race

8. Marital status

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29. Date of death

1. Name of deceased

2. Date of death

3. Place of death

4. Cause of death

5. Age at death

6. Sex

7. Race

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FEB 8 1956

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